We are pleased you have scheduled your Initial Evaluation at Transitions Physical Therapy!

1. Please fill out the patient intake form.
2. Please select and fill out the questionnaire that corresponds to your area of pain.
3. Please bring the patient intake form/ questionnaire to your appointment.
4. Please bring your insurance card.

Please do not hesitate to contact us at our
Essex clinic (802.857.5976),
Jericho clinic (802.899.5200) or
Shelburne clinic (802.489.5494)
if you have any questions.
See you soon!

Transitions Physical Therapy

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

TRANSITIONS PHYSICAL THERAPY, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at TRANSITIONS PHYSICAL THERAPY, LLC, please contact Sean Fitzgerald, PT, and Privacy Officer at (802)-899-5200. **Effective Date of this notice: September 1, 2012**

I. How TRANSITIONS PHYSICAL THERPAY, LLC, may use or disclose your health information:

Transitions Physical Therapy collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of Transitions Physical Therapy, but the information in the medical record belongs to you.Transitions Physical Therapy protects the privacy of your health information. The law permits Transitions Physical Therapy to use or disclose your health information for the following purposes:

1. TREATMENT. Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient. An example of this would be a consultation/discussion with your physician regarding your plan of care, progress, or status.
2. PAYMENT. Payment means reimbursement for the provision of health care; determinations of eligibility or coverage; billing;, claims management, collection activities, justification of charges, protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for healthcare services to your insurance company.
3. REGULAR HEALTH CARE OPERATION. Healthcare operations are any activity related to covered functions in which we participate in the function of our office, such as conducting quality assessment activities, protocol development, case management, and care coordination, auditing functions, business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; and marketing for which an authorization is not required. An example of this would be an evaluation of customer service given to patients.
4. INFORMATION PROVIDED TO YOU
5. NOTIFICATION AND COMMUNICATION WITH FAMILY. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. REQUIRED BY LAW/LAW ENFORCEMENT. As required by law, we may use and disclose your health information, i.e.: to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
7. PUBLIC HEATH. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medication; and reporting disease or infection exposure.
8. HEALTH OVERSIGHT ACTIVITIES. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

9. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceedings.
10. WORKER'S COMPENSATION. We may disclose your health information as necessary to comply with worker's compensation laws.

II. When Transitions Physical Therapy May Not Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Transitions Physical Therapy will not disclose your health information without your written authorization. If you do authorize Transitions Physical Therapy to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Transitions Physical Therapy, LLC is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location.
3. You have the right to inspect and copy your health information.
4. You have a right to request that Transitions Physical Therapy, LLC amend your health information that is incorrect or incomplete. Transitions Physical Therapy, LLC is not required to change your health information and will provide you with information about Transitions Physical Therapy, LLC denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by Transitions Physical Therapy, LLC, except that Transitions Physical Therapy does not have to account for the disclosures described in parts 1 (treatment), 2 (payment), 3 (health care operations), 4 (information provided to you), 5 (directory listings), and 16 (government functions) of section I of this Notice of Privacy Practices.
6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact Sean Fitzgerald, PT, Privacy Officer, Transitions Physical Therapy (802)-899-5200.

IV. Changes to this Notice Of Privacy Practices

Transitions Physical Therapy reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, Transitions Physical Therapy is required by law to comply with this Notice. Revised notices will be given at any time requested.

V. Complaints

Complaints about this Notice of Privacy Practices or how Transitions Physical Therapy handles your health information should be directed to: Sean Fitzgerald, PT, Privacy Officer.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Dept. of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg, 200 Independence Ave, S.W., Room 509F HHH Building, Washington, DC 20201 or address your complain to a regional office found at www.hhs.gov/ocr/regmail.html.

Transitions Physical Therapy

Acknowledgement of Receipt of HIPAA Notice

Transitions Physical Therapy

Sean Fitzgerald, MPT, CSCS Privacy officer

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship:
_____

Name of patient: _____

---------- ***For office use only:***

Signed form received by: _____

Acknowledgement refused:

Efforts to obtain:
_____

Reason for refusal:
_____

Transitions Physical Therapy

MEDICALLY INFORMED CONSENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of services at Transitions Physical Therapy. It is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. This consent shall be ongoing for a period not to exceed one year.

I, a Transitions Physical Therapy patient, have read this form and fully understand and accept its terms and conditions.

_____ _____

Patient (or person authorized to consent for patient/relationship) Date/Time

_____

Witness signature

COMMUNICATION CONSENT

I voluntarily consent to communication with Transitions Physical Therapy beyond the clinic setting which may include mailings to my home, email and phone calls. I understand that my contact information will only be used by Transitions Physical Therapy and will not be given to any other company or organization.

_____ _____

Patient (or authorized to consent for patient/relationship) Date/Time

CANCELLATION POLICY

I understand and agree with Transitions Physical Therapy's NO SHOW/CANCELLATION/ RESCHEDULING policy: **I will be charged a $75.00 fee in the event that I miss an appointment, cancel and / or reschedule in less than a 24-hour (1 business day) period. Personal Training clients will be charged for a full session.**

_____ _____

Signature Date/Time

Transitions Physical Therapy

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to Transitions Physical Therapy and understand that I am financially responsible for non-covered services. I understand that if Transitions Physical Therapy does not contract with my insurance company, I am responsible for the fee for service charges. I also authorize the physician and/or Transitions Physical Therapy to release any information necessary to process this claim. All the information provided below is correct and true to the best of my knowledge.

Your initials and signature below indicate you agree with the Assignment and Release policy.

_____ I understand that I have a copay of_____ which is due on date of service.

OR

_____I understand that I am paying $40 per visit on date of service towards my coinsurance balance. This payment will be applied to my account. I understand that I will receive a monthly statement with remaining patient responsibility as processed by my insurance.

_____I understand that upon receipt of my statement, I am required to pay the balance within 15 days of the statement date.

_____ _____

Signature Date/Time

Payment Options

Please mark how you plan to pay for the patient responsibility charges as processed by your insurance.

_____ I will provide payment with check. (* Please note - A credit card on file is still required.)

_____ I will provide payment with credit card.

_____ I will provide payment using an HSA account.

_____ I will provide payment through my employer.

Employer payment program name: _____

Employer: _____

HSA/Credit Card Information

Transitions Physical Therapy does require a health savings account card or credit card to be kept on file to ensure copayment on date of service, coinsurance fees and remaining account balances that fall to patient responsibility.

_____

Card Number Expiration Date

_____

Name on Card

I would like to speak the Practice Manager about cost of physical therapy services based on my insurance.

_____ Yes _____ No Insurance: _____

Transitions Physical Therapy

PATIENT REGISTRATION FORM

DATE _____

PATIENT NAME *(FIRST)* _____ *(MI)* _____ *(LAST)* _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___ GENDER ID _____ PRONOUNS_____

PHONE *(HOME)* _____ *(WORK)* _____ *(CELL)*

EMAIL ADDRESS _____(*EXERCISES ARE SHARED THROUGH EMAIL*)

ADDRESS: _____

EMPLOYER _____ JOB TITLE _____ *(FULL TIME)* _____ *(PART TME)* _____

STUDENT _____ NO ____ YES *(WHERE)* _____ *(FULL TIME)* _____ *(PART TME)* _____

EMERGENCY CONTACT _____ *(PHONE)*_____ *(RELATIONSHIP)* _____ INJURY / ACCIDENT DATE _____/_____

REFERRING DOCTOR:*(FIRST)* _____*(LAST)* _____ ___ MD ___ DDS ___ DO ___ DC__NP__ND__PA-C *(CITY)* _____ *(STATE)* _____next visit with referring provider?_____

PRIMARY CARE PHYSICIAN:*(FIRST)* _____ (*LAST)*_____ MD ___ DDS ___ DO ___ DC __NP__ND__ PA-C *(CITY)* _____ *(STATE)* _____

HOW DID YOU HEAR ABOUT US?

_____ FAMILY _____ FRIEND _____DOCTOR _____ NEWSPAPER AD _____ CHURCH BULLETIN _____ OTHER_____

IF A FRIEND OR FAMILY MEMER REFERRED YOU, PLEASE TELL US WHO SO WE MAY THANK THEM.

_____

PRIMARY INSURANCE INORMATION:

INSURANCE COMPANY NAME _____

IDENTIFICATION # _____ GROUP # _____

INSURED / POLICY HOLDER NAME *(FIRST)* _____ *(MI)* ____ *(LAST)* _____

RELATIONSHIP ___SELF___SPOUSE ___MOTHER ___FATHER ___OTHER

*(ADDRESS)*_____ *(CITY)* _____ *(STATE)* _____ *(ZIP)* _____

(HOME PHONE) _____ *(DATE OF BIRTH)*_____ EMPLOYER _____

WORKERS COMP INFORMATION:

INSURANCE COMPANY NAME _____

ADDRESS _____

TELEPHONE # _____ CASE MANAGER NAME _____

CLAIM # _____

Transitions Physical Therapy

Patient Health Information

Name_____ Today's Date_____

Age_____ Date of Birth _____ Height_____ Weight_____

Employer_____Occupation_____Regular Exercise_____ Dominance: hand___leg___

Chief Complaint: What brings you to physical therapy? _____

Were you Referred to us?_____ If so when is your next visit with referring provider?_____

Have you been to Physical Therapy before?_____ Have you been to us before?_____

Are you taking any medications? YES NO (If Yes, please list on next page or provide a list)

Are you allergic to LATEX? YES NO

Do you take blood thinners? YES NO

Do you now have, or have you had, any of the following?

High blood pressure	YES	NO	Pace Maker	YES	NO
Heart disease/attack	YES	NO	Seizures	YES	NO
Angina/chest pain	YES	NO	Metal Implants	YES	NO
Dizziness	YES	NO	Fibromyalgia	YES	NO
Cancer	YES	NO	Chronic Headaches	YES	NO
Pregnant (Recent or currently)	YES	NO	Prior Physical Therapy	YES	NO
Previous surgeries	YES	NO	Tooth or jaw pain	YES	NO
Diabetes	YES	NO	Knee support/brace	YES	NO
Osteoporosis	YES	NO	Back support/brace	YES	NO
Rheumatoid Arthritis	YES	NO	Allergies/Asthma	YES	NO
Kidney Disease	YES	NO	Osteoarthritis	YES	NO
Liver Disease	YES	NO	Lung Disease	YES	NO
Smoking/tobacco use	YES	NO	Ulcers	YES	NO
Sexually Transmitted Disease	YES	NO	Stroke	YES	NO
Recent change in vision or glasses	YES	NO	Foot Problems	YES	NO
Recent visits to the ER or MD	YES	NO	Recent Dental work	YES	NO
Family History for any of these	YES	NO	Recent Illness	YES	NO
			Recent infection	YES	NO

If you answered YES to any of the above, please explain and give approximate dates: _____

Currently I am experiencing (circle all that apply): Fever/chills/sweats Poor balance (falls)

Unexplained weight loss Numbness or Tingling Changes in appetite Difficulty swallowing

Depression Shortness of breath Dizziness Headaches

Changes in bowel or bladder function Fatigue Nausea /Vomiting Increased pain at night

Pelvic PT(circle all that apply): Leaking during exercise Pelvic Floor Pain Constipation Painful Intimacy

Incontinence Prolapse Diastasis-Recti Are you interested in learning about our Pelvic Health services? YES NO

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

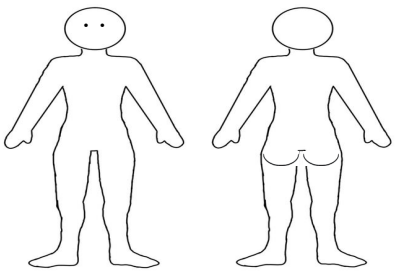
Current Medications

Please list the following: - Prescription Medications - Over-the-Counter Medications - Herbals - Vitamin/Mineral/Dietary Nutritional Supplements

Medication	Dosage	Frequency	Route of Administration	Reason for taking Medication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Patient Name: _____ Date: _____

Verified by: _____ Date: _____



1) **Please indicate on the picture the location of your symptoms.**
2) **Please indicate your level of symptoms for the follow categories:**

Worst____ Best___ Current___

No symptoms= 0 1 2 3 4 5 6 7 8 9 10 =Worst

For the therapist: Cough/Sneeze, + / Saddle Anesth, + /- Bwl/Bldder Chnge,+ /- Numb/Ting.

Current Symptoms:

How did your symptoms start and when? _____

How would you describe your symptoms? ❑Sharp ❑ Dull ❑Aching ❑Burning ❑Radiating ❑Shooting ❑Tingling ❑Stabbing ❑Sore ❑Strained ❑Stiff ❑Other_____

Your symptoms are currently: ❑Getting better / ❑About the same / ❑Getting worse

How often (% of your day) are your symptoms present: constant ❑76-100% Frequently ❑51-75% occasionally ❑26-50% Intermittently ❑0-25%

Easing Factors: Identify up to 3 positions or activities that make your symptoms better:
(Examples: rest, hot or cold, activity) 1. _____ 2._____ 3._____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Evening ❑ Night ❑Being still ❑ With Activity

When are your symptoms the best? ❑ Morning ❑ Evening ❑ Night ❑Being still ❑ With Activity

Treatment History and Goals:

Have you seen anyone else for this problem (MD, Chiropractor, other)? Please list 1_____

Have you had an x-ray, MRI, or other imaging study done? Yes___ NO___ 2 _____

Have you ever had this problem before? Yes___ NO_____ 3 _____

What are your goals and expectations for therapy? _____ 4_____

Is there anyone that you would like us to coordinate care with? _____

Patient Specific Functional Scale : Please identify up to three important activities that you are unable to do or are having difficulty with as a result of your current problem and score those activities with your current level of being able to perform that task.

Activity 1_____ score-__ ***Activity 2***. _____ score- __ ***Activity 3***. _____ score-___

0 1 2 3 4 5 6 7 8 9 10

I am unable to perform the activity at all.

I can perform the activity at the same level as before the current problem.

Please answer one of the following questionnaires that corresponds to where you are having symptoms.

LOWER EXTREMITY PAIN (HIP, LEG, KNEE, SHIN, ANKLE & FOOT PAIN)

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability associated with lower extremity symptoms. **Please circle the answers below that best apply.**

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

Back Pain

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability associated with back pain. **Please circle the answers below that best apply.**

1. **Please rate your pain level with activity:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

1. Pain Intensity
(0) I can tolerate the pain I have without having to use pain medication.
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from pain.
(5) Pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)
(0) I can take care of myself normally without causing increased pain.
(1) I can take care of myself normally, but it increases my pain.
(2) It is painful to take care of myself, and I am slow and careful.
(3) I need help, but I am able to manage most of my personal care.
(4) I need help every day in most aspects of my care.
(5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting
(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights, but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. Walking
(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from walking more than 1 mile.
(2) Pain prevents me from walking more than ½ mile.
(3) Pain prevents me from walking more than ¼ mile.
(4) I can only walk with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting
(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) Pain prevents me from sitting at all.

6. Standing
(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want but, it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than 1/2 hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

7. Sleeping
(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hour
(5) Pain prevents me from sleeping at all.

8. Social Life
(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

9. Traveling
(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys journeys under 1/2 hour.
(5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking
(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.

NECK PAIN

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability associated with neck pain. **Please circle the answers below that best apply.**

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

NECK DISABILITY INDEX – INITIAL VISIT

1. Pain Intensity
- (0) I have no pain at the moment.
- (1) The pain is very mild at the moment.
- (2) The pain is moderate at the moment.
- (3) The pain is fairly severe at the moment.
- (4) The pain is very severe at the moment.
- (5) The pain is the worse imaginable at the moment.

2. Personal Care (washing, dressing, etc)
- (0) I can look after myself normally without extra pain.
- (1) I can look after myself normally but it causes extra pain.
- (2) It is painful to look after myself and I am slow and careful.
- (3) I need some help but manage most of my personal care.
- (4) I need help every day in most aspects of self care.
- (5) I cannot get dressed, wash with difficulty and stay in bed

3. Lifting
- (0) I can lift heavy weights without extra pain.
- (1) I can lift heavy weights but it gives me extra pain.
- (2) Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
- (3) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

4. Headache
- (0) I have no headaches at all.
- (1) I have slight headaches which come infrequently.
- (2) I have moderate headaches which come infrequently.
- (3) I have moderate headaches which come frequently.
- (4) I have severe headaches which come infrequently.
- (5) I have headaches almost all the time.

5. Recreation
- (0) I am able engage in all my recreational activities without pain.
- (1) I am able to engage in my recreational activities with some pain.
- (2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
- (3) I am able to engage in a few of my usual recreational activities with some neck pain.
- (4) I can hardly do any recreational activities because of neck pain.
- (5) I can't do any recreational activities at all.

6. Reading
- (0) I can read as much as I want with no pain in my neck.
- (1) I can read as much as I want with slight neck pain.
- (2) I can read as much as I want with moderate neck pain.
- (3) I can't read as much as I want because of moderate neck pain.
- (4) I can hardly read at all because of severe neck pain.
- (5) I cannot read at all because of neck pain.

7. Work
- (0) I can do as much as I want to.
- (1) I can only do my usual work but no more.
- (2) I can do most of my usual work but no more.
- (3) I cannot do my usual work.
- (4) I can hardly do any usual work at all.
- (5) I can't do any work at all.

8. Sleeping
- (0) Pain does not prevent me from sleeping well.
- (1) My sleep is slightly disturbed (<1 hr sleep loss).
- (2) My sleep is mildly disturbed (1-2 hr sleep loss).
- (3) My sleep is moderately disturbed (2-3 hr sleep loss).
- (4) My sleep is greatly disturbed (3-4 hr sleep loss).
- (5) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration
- (0) I can concentrate fully when I want with no difficulty.
- (1) I can concentrate fully when I want with slight difficulty.
- (2) I have a fair degree of difficulty concentrating when I want.
- (3) I have a lot of difficulty concentrating when I want.
- (4) I have great difficulty concentrating when I want.
- (5) I cannot concentrate at all.

10. Driving
- (0) I can drive my car without neck pain.
- (1) I can drive my car as long as I want with slight neck pain.
- (2) I can drive my car as long as I want with moderate neck pain.
- (3) I can't drive my car as long as I want because of moderate pain.
- (4) I can hardly drive my car at all because of severe neck pain.
- (5) I can't drive my car at all.

PATIENT NAME: _____ **DATE:** _____

Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, **how much they bother you**. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Please rate your symptom level with activity: NO symptoms = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE symptoms

			If yes, how much does it bother you?			
			Not at all	Somewhat	Moderately	Quite a bit
1.	Do you usually experience pressure in the lower abdomen?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
2.	Do you usually experience heaviness or dullness in the lower abdomen?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
3.	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
4.	Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
5.	Do you usually experience a feeling of incomplete bladder emptying?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
6.	Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
7.	Do you feel you need to strain too hard to have a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
8.	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
9.	Do you usually lose stool beyond your control if your stool is well formed?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
10.	Do you usually lose stool beyond your control if you stool is loose or liquid?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
11.	Do you usually lose gas from the rectum beyond your control?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)

12.	Do you usually have pain when you pass your stool?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
13.	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
14.	Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
15.	Do you usually experience frequent urination?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
16.	Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
17.	Do you usually experience urine leakage related to laughing, coughing, or sneezing?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
18.	Do you usually experience small amounts of urine leakage (that is, drops)?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
19.	Do you usually experience difficulty emptying your bladder?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
20.	Do you usually experience pain of discomfort in the lower abdomen or genital region?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)

Barber MD, Walters MD, Bump RC. Short forms of two condition-specific quality-of-life questionnaires for women with pelvic floor disorders (PFDI-20 adn PFIQ-7). Am J Obstet Gynecol 2005;193:103-113.

UPPER EXTREMITY PAIN (SHOULDER, ARM, HAND PAIN)

Date:_____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities associated with upper extremity pain.

Please answer every question, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task. **1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN**

Quick DASH - Initial

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Balance and Falls: Modified Falls Efficacy Scale

Today's Date: ____/____/____ Date of Birth: ____/____/____

Name: _____

How many times have you fallen in the last month?

0	1	2	3	4	5	6	7	8	9	10

INSTRUCTIONS: On a scale of 0 to 10, how confident are you that you can do each of these activities without falling, with 0 meaning "not confident/not sure at all", 5 being "fairly confident/fairly sure", and 10 being "completely confident/completely sure"?

If you have stopped doing the activity at least partly because of being afraid of falling, score a 0;
If you have stopped an activity purely because of a physical problem, leave that item blank
If you do not currently do the activity for other reasons, please rate that item based on how you perceive you would rate if you had to do the activity today.

	NOT CONFIDENT AT ALL				FAIRLY CONFIDENT						COMPLETELY CONFIDENT
1. Get dressed and undressed	0	1	2	3	4	5	6	7	8	9	10
2. Prepare a simple meal	0	1	2	3	4	5	6	7	8	9	10
3. Take a bath or a shower	0	1	2	3	4	5	6	7	8	9	10
4. Get in/out of a chair	0	1	2	3	4	5	6	7	8	9	10
5. Get in/out of bed	0	1	2	3	4	5	6	7	8	9	10
6. Answer the door or telephone	0	1	2	3	4	5	6	7	8	9	10
7. Walk around the inside of your house	0	1	2	3	4	5	6	7	8	9	10
8. Reach into cabinets or closet	0	1	2	3	4	5	6	7	8	9	10

	NOT CONFIDENT AT ALL				FAIRLY CONFIDENT						COMPLETELY CONFIDENT
9. Light housekeeping	0	1	2	3	4	5	6	7	8	9	10
10. Simple shopping	0	1	2	3	4	5	6	7	8	9	10
11. Using public transport	0	1	2	3	4	5	6	7	8	9	10
12. Crossing roads	0	1	2	3	4	5	6	7	8	9	10
13. Light gardening or hanging out the washing*	0	1	2	3	4	5	6	7	8	9	10
14. Using front or rear steps at home	0	1	2	3	4	5	6	7	8	9	10

* RATE MOST COMMONLY PERFORMED OF THESE ACTIVITIES