PEMI-BAKER COMMUNITY HEALTH

HOME HEALTH • HOSPICE • REHAB THERAPIES • AQUATIC & FITNESS

PATIENT AGREEMENT

PERMISSION FOR EVALUATION AND TREATMENT: I hereby give permission to the professional staff of Pemi-Baker Community Health to perform any test(s) and give any treatment(s), deemed appropriate by the professional(s) responsible for my care.

TEAM APPROACH: Pemi-Baker Community Health encourages general wellness. Our goal is to help patients return to their greatest functional capacity. I understand that I may be treated by more than one of the healthcare personnel over the course of care at the discretion of the Professional performing the initial evaluation. I understand that there is a high level of communication between the providers of my care, verbal and written, in providing the optimum attention. If I feel most comfortable with one provider, I have the freedom to request an individual provider as my choice. Your physical therapy initial evaluation will be provided by a Physical Therapist who is licensed in the state of NH to provide care to a broad range of patients and diagnoses. Subsequent treatments may be provided by a Physical Therapist or a Physical Therapist Assistant who is a NH licensed professional providing care for a broad range of patients and diagnoses. All physical therapy at the Pemi-Baker Community Health is supervised and reviewed by the evaluating Physical Therapist.

NO SHOW/CANCEL POLICY: I understand that attendance is important to the success of my rehabilitation goals. If necessary I agree that I will cancel appointments at least 24 hours in advance. I understand that if I have three no-shows for my scheduled visits I will be discharged from physical therapy

PAYMENT AGREEMENT: I permit Pemi-Baker Community Health to bill my insurance carrier directly and request any payments for service to be made directly to Pemi-Baker Community Health. I certify the insurance identification information given by me is accurate. I understand that I am responsible for and agree to pay **all** applicable copays, deductible amounts and charges not covered by my insurance at the time of treatment.

RELEASE OF INFORMATION: I hereby authorize Pemi-Baker Community Health to release any information necessary in coordination of my care to my insurance company(s), my attending physician(s) and/or case manager(s).

NOTICE OF PRIVACY PRACTICES: I have been shown and offered a copy of the Pemi-Baker Community Health **Notice of Privacy Practices.** I understand and accept the Pemi-Baker Community Health HIPPA information and know that I can contact the Executive Director with any concerns or complaints.

PERSONAL PROPERTY STATEMENT: I hereby release Pemi-Baker Community Health of any responsibility for the loss or theft of any personal items left in any section of Pemi-Baker Community Health. Locks are available at the front desk and need to be returned at the end of your exercise session.

PATIENTS' BILL OF RIGHTS: I hereby acknowledge that I have received a copy of the Patients' Bill of Rights, pursuant to RSA-151:21.

I understand all statements made above and agree to its terms.

_____ _____

Patient Signature (or guardian if patient is under 18) Date

_____ _____

Witness Date

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Name: _____ Referring provider: _____

Date seen by Physician: _____ Next Physician appointment: _____

Are you taking medication regularly? Yes _____ No ____
If yes, please list medications: _____

Do you have a "Do Not Resuscitate" (DNR) order we need to follow in case of an emergency? Yes ____ No ____

Do you have or have you been treated for any of the following conditions? (please circle Yes or No)

Arthritis	Yes	No	Frequent Headaches	Yes	No
Allergies	Yes	No	Hearing Impairment	Yes	No
Environmental	Yes	No	Hepatitis/Jaundice	Yes	No
Medication	Yes	No	Hernia	Yes	No
Latex	Yes	No	High Blood Pressure	Yes	No
Anxiety	Yes	No	Liver Disease	Yes	No
Asthma	Yes	No	Lung Disease	Yes	No
Bowel/Bladder problems	Yes	No	Major injuries/illness	Yes	No
Cancer	Yes	No	Neurological conditions	Yes	No
Cardiac History	Yes	No	Nutritional deficiency	Yes	No
Chest Pain	Yes	No	Operations	Yes	No
Chronic Cough	Yes	No	Osteoporosis	Yes	No
Chronic skin disease	Yes	No	Pacemaker	Yes	No
Communicable Disease	Yes	No	Phlebitis	Yes	No
Congestive Heart Failure	Yes	No	Reflux/Heartburn	Yes	No
Convulsions/Seizures	Yes	No	Shingles (Zoster)	Yes	No
Depression	Yes	No	Shortness of Breath	Yes	No
Diabetes	Yes	No	Thyroid condition	Yes	No
Dizziness	Yes	No	Vision Problems	Yes	No
Falls	Yes	No			
Fainting Spells	Yes	No	Other: _____		
Fractures	Yes	No			

If you answered yes for any of the above conditions, please explain: _____
_____
_____
_____
_____

*** If you discover you have any of the above conditions during your course of treatment please notify a staff member immediately***

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Our practice is to demonstrate and discuss your home program. Please identify any specific learning styles you may prefer:

_____ None _____ Written Description ____ Pictures ____ Participation

_____ Other: _____

Have you had any previous therapy (Cardiac Rehab, Pulmonary Rehab, Physical Therapy, Occupational Therapy, Speech Therapy) here or at another facility in the last year?

____ No ____ Yes (explain): _____

1) Date of onset of symptoms: _____ Have you had a similar problem in the past? ____ Yes ____No
2) How did the problem occur? (fall, auto accident, etc.) _____
_____
3) Medical Treatment so far? (casting, surgery, diagnostic tests, etc. Please include dates) _____
_____
_____
4) Are your present symptoms _____ Constant _____ Intermittent
5) Is the pain worse Morning Midday Evening Night
   Is the pain better Morning Midday Evening Night
6) Do certain activities make the pain worse? Please specify: _____
   Do certain activities make the pain better? Please specify: _____
7) Are you getting Better Worse Staying the same
8) If pain is present, use the pain scale below to tell us the rating of your pain at its worst and best.

_____

0 1 2 3 4 5 6 7 8 9 10

No pain **Unbearable pain**

9) Please check what you are presently having difficulty with:

Dressing Upper body	Yes	No	Stairs	Yes	No
Dressing Lower body	Yes	No	Bending	Yes	No
Cooking	Yes	No	Squatting	Yes	No
Eating	Yes	No	Lifting	Yes	No
Washing	Yes	No	Work Duties	Yes	No
Grooming	Yes	No	House/yard work	Yes	No
Shaving/brushing teeth	Yes	No	Child Care	Yes	No
Bathroom Mobility	Yes	No	Recreation/hobbies	Yes	No
Sleeping	Yes	No	Grasping/gripping	Yes	No
Reaching out in front/overhead	Yes	No	Getting in/out of car	Yes	No
Driving How Long?	Yes	No	Sitting How Long?	Yes	No
Standing How Long?	Yes	No	Walking How Long?	Yes	No

What do you hope to achieve from therapy? _____

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

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PATIENT INTAKE

NAME (last, first): _____ DOB: _____ SS# _____

MAILING ADDRESS: _____
(Street) (City/Town, State, Zip Code)

PHONE (HOME): _____ (WORK): _____ (CELL): _____

EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ FACILITY: _____

DX: _____

HAVE YOU HAD PRIOR PHYSICAL THERAPY (AS OF JANUARY 1ST)? Yes ___ No__ WHERE? _____

EMERGENCY CONTACT: _____ **RELATIONSHIP**: _____

ADDRESS: _____ **HOME PHONE**: _____

_____ **CELL PHONE**: _____

CONSENT TO SHARE INFORMATION (Other than health care provider and insurance companies)

Please list all individuals that may obtain your information, including any and all legal guardians if a (a minor) or (unable to consent):

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

I give my consent for Pemi-Baker Community Health to share my Hospice Election and Advanced Directives with local EMS and hospitals. _____ (Initial)

Notice of Privacy Practices:

By my signature below, I give my permission for Pemi-Baker Community Health to share all information know to them with the individuals listed above.

Patient signature: _____ Date: _____

The undersigned certifies that the patient is (unable to consent) (a minor) and the undershigned certifies that he/she has read and agrees to the above as the responsible part of the patient.

Responsible Party Signature: _____ Date: _____