BRANSON PHYSICAL THERAPY, LLC.

850 S Ironwood Dr., 112 Apache Junction, AZ 85120-6242

Patient Information Form

Please read carefully and complete all questions as they are regulated by HIPPA.

Name: ____ Home Phone: ________________________

Social Security #: ________________________ Date of Birth: ________________ Sex: ________ Age: _______

Local Address: ____ Apt(sp): __________________

City: ______________________________________ State: _________________ Zip: ___________________

Out of State Address: ____ Apt(sp): ________________

City: ______________________________________ State: _________ Zip: _______ Phone #: _____________

Spouse's Name: _______________________________ Phone #: _________________________________

Spouse's Social Security #: __________________________________ Date of Birth: ____________________

Employed by: ________________________________ Position: _____________________________________

Business Address: ____________________________ City: ______________ State: ______ Zip: ____________

Business Phone #: ______________________ Ext.: _______ Supervisor Name: _________________________

Who is responsible for this bill? ____

Referred by: ____ Phone #: ___________________________

Whom may we contact in the case of an emergency? ____

Phone #: ______________________________ Relationship to patient: ______________________________

I authorize Branson Physical Therapy to treat me for the following diagnosis/condition __________________

____

Is this injury related to an Auto accident or is this part of a litigation? ___Yes ___No

If you have answered Yes, please advise us right away, as we NO LONGER ACCEPT Litigation cases.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered by Branson Physical Therapy, LLC. I have read all the information on this sheet and have completed all of the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

____ ___________________________

Signature Date

____ ___________________________

Parent/Guardian (if minor) Date

Branson Physical Therapy
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Apache Junction AZ 85120-6242
PHONE (480) 983-1680
FAX (480) 983-1681

Patient Questionnaire Form

This questionnaire is designed to help us obtain necessary information about your health problems and your activity level. If you have difficulties answering or understanding these questions, please ask for assistance.

Name ______________________________ Date: __________

Age ______ Sex: **M** **F** Height __________ Weight __________ ☐ Right Handed ☐ Left Handed

Is your problem due to any of the following?

☐ Surgery ☐ Auto Accident ☐ Slip/Fall
☐ Sports Injury ☐ Gradual Onset of symptoms ☐ Lifting/Pulling
☐ Other Cause: ______________________________

Date of injury / onset of your problem: ______________ **or...**
How long have you experienced this present problem? (months/years) ______________

How you describe your symptoms? ☐ Ache/Dull ☐ Burning ☐ Numbness
☐ Spasm/ cramp ☐ Pins & Needles ☐ Stabbing/sharp
☐ No pain, I just can't do some things ☐ Stiffness ☐ Shooting
☐ Other ______________________________

Please place two checks on the line to rate your pain at it's **best** and **worst** in the past three days, on a zero to ten scale, with zero being no pain and ten as the worst your symptoms could be:

No Pain ______________________________ **Worst it could be**
0 1 2 3 4 5 6 7 8 9 10

What activities are you unable to do or are having difficulty with as a result of your problem?

A. ______________ D. ______________
B. ______________ E. ______________
C. ______________ F. ______________

Are there specific movements or treatments that *relieve* your symptoms? **Y** **N**
If yes, Specify ______________________________

Is your problem getting... ☐ better ☐ worse ☐ about the same

Have you experienced similar problems in the past? **Y** **N** **If** yes...
How frequently did you have flare-ups? ______________________________
Have you had previous treatment? **Y** **N** If yes...What type(s) of treatment? (include dates) ______________

Please continue on other side ->

0	1	2	3	4	5	6	7	8	9	10
Unable to Perform activity.										Able to perform activity at same level as before injury or problem.

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Past Medical History

(Please check if any of the following conditions apply to you)

- [ ] Asthma
- [ ] Allergies ____________
- [ ] Alcoholism
- [ ] Diabetes
- [ ] Heart Disease ____________
- [ ] High blood pressure
- [ ] Thrombophlebitis
- [ ] Lung Disease ____________
- [ ] Rheumatoid arthritis
- [ ] Osteoarthritis (degenerative joint disease)
- [ ] Joint/Bone infection
- [ ] Lupus Erthematosis
- [ ] Psoriasis
- [ ] Gout
- [ ] Cancer ____________
- [ ] Venereal Disease
- [ ] Seizure Disorder
- [ ] Faintness
- [ ] Muscle Weakness - Where? ____________
- [ ] Numbness - Where? ____________
- [ ] Joint Pain - Where? ____________
- [ ] Swelling - Where? ____________

Have you experienced unusual weight loss? ☐ Yes ☐ No

Have you been admitted to the hospital or undergone any surgical procedures during the past five years? ☐ Yes ☐ No

Please list, including dates ____________

____

____

Please list the medications you are currently taking:

____

____

____

Have you received any injections in the joints or muscles?

☐ Yes ☐ No If yes, please list with dates

____

____

Please list any special braces, orthotics, canes, etc, that you use ____________

____

Have you received any special tests recently? ☐ Yes ☐ No

Example: Xray, MRI, CAT scan, bone scan, EMG, EKG, Stress test: Please Specify ____________

____

Exercise History

How much exercise do you get?

- [ ] None
- [ ] Walk ____________ miles/week
- [ ] Jog/run ____________ miles/week

Please list the sport / recreational activities that you are involved in. ____________

____

____

____

____

____

____

____

____

____

____

____

How long have you been doing this?

- [ ] 3 to 6 months
- [ ] 6 months to one year

____________ years

Social History

Do you smoke? ☐ Yes ☐ No #per day: ____________

How much did you smoke in the past?

____

Do you drink alcholic beverages? ☐ Yes ☐ No

- [ ] Daily
- [ ] Socially
- [ ] Rarely

Do you drink caffeinated beverages? ☐ Yes ☐ No

Number of cups/beverages per day: ____________

Thank You!

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	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, re creational 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
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses.

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