The Therapy Institute
EXCELLENCE IN PHYSICAL THERAPY SINCE 1989

Patient Information Form

Patient Information

Last Name _____ First Name_____ MI____ Preferred Name_____

DOB____/____/_____ SS #_____-_____-_____ Sex_____ Marital Status_____

Address_____

Address #2_____ City_____ State_____ Zip_____

Email: _____ **How did you hear about us?** _____

Contact Information:

	Can we leave a message at number below
Home phone:	Y / N
Work phone:	Y / N
Cell Phone:	Y / N

Emergency Contact

Last Name_____ First Name_____ MI_____ Relationship_____

Phone_____

Employer

Name_____ Phone_____

Address_____

State_____ Zip_____

Problem

Problem Description_____ Date of Injury_____/____/_____ Last Physician Visit_____/____/_____

Referred By_____

Notes:_____

Did the injury happen at work? Y / N If yes, is this workers compensation?_____

Claim #_____ **Case Manager Name**_____ **Phone**___-_____-_____

Was injury related to Auto Accident? Y / N **If yes, what state did it occur in:**_____

Policy #_____ **Case Manager/Adjuster Name**_____ **Phone**_____-_____-_____

Primary Insurance

Insurance_____ Primary Subscriber Name_____ DOB_____

ID_____ Group #_____ Relationship_____

Secondary Insurance

Insurance_____ Primary Subscriber Name_____DOB_____

ID_____Group #_____Relationship_____

Tertiary Insurance

Insurance_____ Primary Subscriber Name_____DOB_____

ID_____Group #_____Relationship_____

HIPAA NOTICE AND ACKNOWLEDGEMENT

I acknowledge that I have received/been offered the Notice of Privacy Practices.

_____ _____/_____/_____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe relationship to patient:

_____

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION (Optional)

My protected health information may be disclosed to:

_____ _____

Name Relationship

_____ _____

Name Relationship

I understand that, as set forth in The Therapy Instiute, LLC Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:
The Therapy Institute, LLC
1660 Haslett Rd, Ste 4
Haslett, MI 48840
ATTN: Privacy Officer

I understand that a revocation is not effective to the extent that The Therapy Institute, LLC has relied on the use or disclosure of the protected health information.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under the federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization

With my signature below I agree to the following:

- I authorize release of information requested by my insurance plan for payment.
- I understand that verification of insurance benefits is done as a courtesy and not a guarantee of payment, coverage, or benefits stated by my insurance carrier.
- I understand that I am financially responsible for any balance not covered by my insurance carrier.
- A copy of this signature is as valid as the original.

_____ Date_____/_____/_____

Signature of Patient or Personal Representative

_____ _____

Printed Name of Patient or Personal Representative Authority of Representative

The Therapy Institute

NAME : _____ **DATE :** _____

Circle YES or NO…

Have you ever been told you have:

Cancer ? ....Yes.....No
Diabetes ?..... .....Yes.....No
High blood pressure ? ....Yes.....No
Heart disease ? ....Yes.....No
Angina/chest pain ?..... .....Yes.....No
Stroke ? ....Yes.....No
Osteoporosis ?..... .....Yes.....No
Osteoarthritis ?..... .....Yes.....No
Rheumatoid arthritis ?.... .....Yes.....No

In the past 3 months have you had or do you experience:

A change in your health ? .....Yes .....No
Nausea/Vomiting ? .....Yes .....No
Fever/chills/sweats ? .....Yes .....No
Unexplained weight change ? .....Yes .....No
Numbness or tingling ? .....Yes .....No
Changes in appetite ? .....Yes .....No
Difficulty swallowing ?.....Yes .....No
Changes in bowel or bladder function ?.....Yes .....No
Shortness of breath ?.....Yes ....No
Dizziness ?.....Yes .....No
Upper respiratory infection ? .....Yes .....No
Urinary tract infection ? .....Yes .....No

Circle YES or NO…

Do you have a history of:

Asthma ? .....Yes .....No
Headaches ? .....Yes .....No
Bronchitis ?.....Yes .....No
Kidney disease ? .....Yes .....No
Rheumatic fever ? .....Yes .....No
Ulcers ? .....Yes .....No
Seizures ? .....Yes .....No
Latex allergies ? .....Yes .....No
Medication allergies ? .....Yes .....No
List_____

Are you currently:

Pregnant ?..... Yes ..... No
Depressed ? ..... Yes ..... No
Under Stress ? ..... Yes ..... No

Are you currently receiving any services to help manage stress and/or depression? YES NO

Are your symptoms: (check one)

☐ Getting worse ☐ The same ☐ Improving

How are you able to sleep at night? (check one)

☐ Fine ☐Moderate difficulty ☐Only with medication

Do you have a problem with ... (check all that apply)

☐ Hearing ☐ Vision
☐ Speech ☐ Communication

Do you or have you in the past smoked tobacco? YES NO

If yes, _____Packs **X** _____Years.

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week? _____/week.

Are you currently involved in a lawsuit? YES NO

Date of last physical examination _____

List medications currently using: _____

_____

_____

List any past surgeries: _____

_____

_____

Name: _____ Date: _____

TMD Disability Index (Steigerwald/Maher)

Please circle the number that corresponds with the one statement that best pertains to you (not necessarily exactly) in each of the following categories.

1. Communication (talking)

0 I can talk as much as I want without pain, fatigue, or discomfort.
1 I can talk as much as I want, but it causes some pain, fatigue and/or discomfort.
2 I can't talk as much as I want because of pain, fatigue and/or discomfort.
3 I can't talk much at all because of pain, fatigue and/or discomfort.
4 Pain prevents me from talking at all.

2. Normal living activities (brushing teeth/flossing).

0 I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
1 I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
2 I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how slow and careful I am.
3 I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
4 I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

3. Normal living activities (eating, chewing).

0 I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
1 I can eat and chew most anything I want, but it sometimes causes some pain/discomfort and/or jaw tiredness.
2 I can't each much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
3 I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
4 I must stay on a liquid diet because of pain and/or restricted opening.

4. Social/recreational activities (singing, playing musical instruments, cheering, laughing, social activities, playing amateur sports/hobbies, and recreation, etc.)

0 I am enjoying a normal social life and/or recreational activities without restriction.
1 I participate in normal social life and/or recreational activities but pain/discomfort is increased.
2 The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instruments, singing).
3 I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
4 I have practically no social life because of pain.

5. Non-specialized jaw activities (yawning, mouth opening and opening my mouth wide).

0 I can yawn in a normal fashion, painlessly.
1 I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
2 I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
3 Yawning and opening my mouth wide are somewhat restricted by pain.
4 I cannot yawn or open my mouth wide more than two finger widths (28-32cm) or, if I can, it always causes greater than moderate pain.

6. Sexual function (including kissing, hugging and any and all sexual activities to which you are accustomed).

0 I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face or jaw pain.
1 I am able to engage in all my customary sexual activities and expression, but it sometimes causes some headache, face or jaw pain, or jaw fatigue.
2 I am able to engage in all my customary sexual activities and expression, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment, willingness and satisfaction.
3 I must limit my customary sexual expression and activities because of headache, face or jaw pain or limited mouth opening.
4 I abstain from almost all sexual activities and expression because of the head, face or jaw pain it causes.

7. Sleep (restful, nocturnal sleep pattern).

0 I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
1 I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aids.
2 I fail to realize 6 hours restful sleep even with the use of pills.
3 I fail to realize 4 hours restful sleep even with the use of pills.
4 I fail to realize 2 hours restful sleep even with the use of pills.

8. Effects of any form of treatment, including, but not limited to, medications, in-office therapy, treatments, oral orthotics (e.g. splints, mouthpieces), ice/heat, etc.

0 I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
1 I can completely control my pain with some form of treatment.
2 I get partial, but significant, relief through some form of treatment.
3 I don't get "a lot of" relief from any form of treatment.
4 There is no form of treatment that helps enough to make me want to continue.

9. Tinnitus, or ringing in the ear(s).

0 I do not experience ringing in my ear(s).
1 I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
2 I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
3 I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
4 I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

10. Dizziness (lightheaded, spinning and/or balance disturbances).

0 I do not experience dizziness.
1 I experience dizziness, but it does not interfere with my daily activities.
2 I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.
3 I experience dizziness which causes a marked impairment in the performance of my daily activities.
4 I experience dizziness which is incapacitating.

Score: _____

Symptom Location

Please indicate on the body chart below where you are experiencing the symptoms that are bringing you into therapy TODAY. Previous symptoms and episodes will be reviewed by your therapist during your evaluation.