CONSULTATION

To help us assist you, please provide us with the information requested below:

Name:______________________________________Date:____________________

Regarding your visit today,
1.What health issue(s) are you being seen for today? Please provide a brief description below.
____
2.Have you undergone any testing for the problem for which you are being seen for today? (X-ray, MRI, EMG, CT Scan, etc.) or treatments? Circle: Yes / No. If you answered yes, please provide a brief description.
____
3.Are you currently taking any medications? Circle: Yes / No. If you answered yes, please list them or provide a list.
____
4.Do you have any other medical conditions for which you are currently being treated? Circle: Yes / No. If you answered yes, please provide a brief description.
____
5.Please indicate any other pertinent information or difficulties you feel are relevant to your visit today. ____

With regard to COVID 19, please provide an explanation for a YES response.
In the past 7 days?
1. Has anyone in your household had a fever or been ill, a cough or shortness of breath, experienced a new loss of the sense of taste or smell? Yes / No
2. To the best of your knowledge, have you been in contact with someone who has COVID-19? Yes / No
Please provide an explanation for a Yes response/s.
____
____
3. Have you been fully vaccinated against Covid-19 ?
Yes: Date of final vaccination ____________________ / No

Staff Use Reviewed By/Date: ____

Clinic Use Only

Plan: ☐ PT Eval ☐ Referral: ☐ Other: Staff Initials Date

PHYSICAL HISTORY & SYSTEM REVIEW (NEW PATIENTS)

BODYWORKS

Name: ______________________ Referred By: ______________________ Date: ________

How did you hear about BODYWORKS? ______________________

Providing the requested information will help us understand your present condition and the impact it has had on your life. Your answers will help to guide our examination and will ensure that this evaluation is as accurate as possible. If you have any questions as you are completing this worksheet, please place a question mark there and your Clinician will discuss those areas.

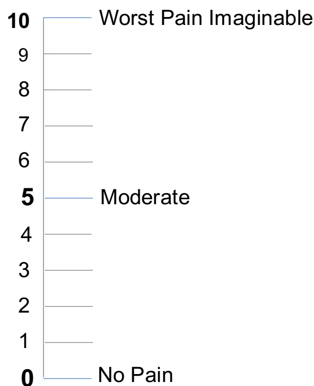
HISTORY OF CURRENT CONDITION

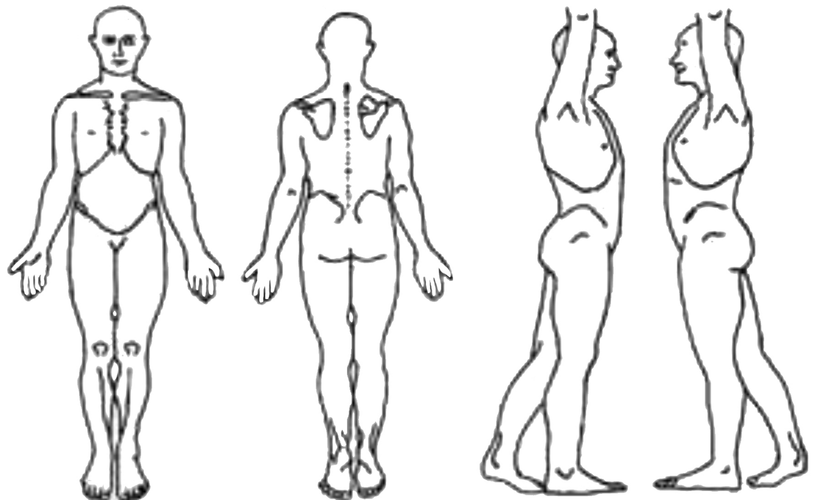
1. What is your main physical complaint/problem? ______________________
2. When did your symptoms first begin? ______________________
3. How did your symptoms initially present themselves? ______________________
4. Was the onset of this episode… ☐ From injury* ☐ Disease ☐ Other:

* If you were injured, how were you injured?* ______________________

On the figures below, shade any areas where you have pain or abnormal sensation(s).
Indicate the intensity of your current level of pain using the scale below.

Pain Intensity Scale





5. Was the onset of this episode…? ☐ Gradual ☐ Delayed ☐ Sudden ________
6. Since the onset, are your symptoms…? ☐ Better ☐ Unchanged ☐ Worse ________
7. How is your pain? (Check all that apply.) ☐ Dull ☐ Aching ☐ Throbbing ☐ Sharp ☐ Constant ☐ Periodic ________
8. Does the pain wake you at night? ☐ No ☐ Yes
9. If yes, is it present when you are… ☐ Lying still ☐ When changing position ☐ Both
10. In what position do you sleep? ☐ Left side ☐ Right Side ☐ On Stomach ☐ On Back ☐ In Recliner or Chair Other: ________
11. Do you have pain/stiffness upon getting out of bed? ☐ Yes ☐ No
12. As the day progresses, is your pain… ☐ Decreased ☐ The Same ☐ Increased

13. What aggravates your pain/symptoms? ______________________

14. What relieves your pain/symptoms? ______________________

15. How many times have you had symptoms similar to your current condition? ____________

16. What previous treatment have you had for this condition? (Check all that apply.)

- ☐ None
- ☐ Medication (oral)
- ☐ Physical therapy
- ☐ Massage therapy
- ☐ Exercise
- Other: ______________________
- ☐ Bracing/taping
- ☐ Casting
- ☐ Traction
- ☐ Injection into the spine
- ☐ Injection into skin/muscles
- ☐ Work conditioning
- ☐ Biofeedback
- ☐ TENS unit
- ☐ Acupuncture
- ☐ Bed rest
- ☐ Surgery (on the body area Of your current problem)
- ☐ Joint Manipulation by a Chiropractor or Osteopath
- ☐ Overnight hospitalization
- ☐ Home health care services

17. Which health professionals are you currently seeing?

Type	Name	Type	Name
☐ Medical/Family Doctor	______	☐ Physical Therapist	______
☐ Chiropractor	______	☐ Massage Therapist	______
☐ Orthopedist	______	☐ Psychiatrist/Psychologist	______
☐ Neurologist/Neurosurgeon	______	☐ Other:	______

18. Which of the following problems have you experienced? (Check all that apply.)

- ☐ Weak/tingly/numbness in both arms at same time
- ☐ Unexplained weight loss
- ☐ Weak/tingly/numbness in both legs at same time
- ☐ Falling/balance problems
- ☐ Fever
- ☐ Visual disturbances
- ☐ Ringing in the ears
- ☐ Numbness in genitals/anus
- ☐ Dizziness or fainting
- Other: ____________

19. Have you fallen in the past 12 months? ☐ Yes ☐ No
How many times? ____________ Were you injured? ☐ Yes ☐ No

20. Which of the conditions below have you ever been diagnosed with? (Check all that apply.)

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Emphysema/Bronchitis
- ☐ Anorexia/Bulimia
- ☐ Multiple Sclerosis
- ☐ Arthritis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Chemical/Alcohol Addiction
- ☐ HIV/Aids
- ☐ Epilepsy/Seizures
- ☐ Depression
- ☐ Mental Illness
- ☐ Asthma
- ☐ Allergies
- ☐ Hepatitis
- ☐ Stroke
- ☐ Other: ____________

21. Which surgeries or other conditions have you been hospitalized for?

Date Surgery/Hospitalization Reason

____

____

____

22. Which injuries (fractures, dislocations, sprains, etc.) have you been treated for recently?

Date Treatment

____

____

23. Which describes an aspect of your current health?

- ☐ Have cardiac pacemaker
- ☐ Have metallic implants
- ☐ Have non-metallic implants
- ☐ Am pregnant
- ☐ Other: ______________________

Functional Levels

For each of the questions below, read the question and answer it twice. First answer how it was before the incident/accident/surgery (check the hollow box ◻) AND then how things are *now* (check the gray box ■).

Living Situation

- ◻ ■ Live in a house
- ◻ ■ Live in an apartment
- ◻ ■ Live in a mobile home
- ◻ ■ Live alone
- ◻ ■ Live with your spouse or a relative
- ◻ ■ Live in a facility that offers care
- ◻ ■ Have stairs in the home/outside

Equipment Needed/Use
- ◻ ■ Cane
- ◻ ■ Walker
- ◻ ■ Wheelchair
- ◻ ■ Grab Bars
- ◻ ■ Elevated/Bedside Commode
- ◻ ■ Hospital Bed
- ◻ ■ Other:

Occupational Situation

- ◻ ■ Employed full-time
- ◻ ■ Self-employed
- ◻ ■ Full-time homemaker
- ◻ ■ Employed part-time
- ◻ ■ Retired
- ◻ ■ Disabled
- ◻ ■ Unemployed
- ◻ ■ Other: ____________

Time Taken Off Work:

Work Related Physical Activities

- ◻ ■ Sitting
- ◻ ■ Using a computer
- ◻ ■ Talking on the phone
- ◻ ■ Driving
- ◻ ■ Moving in a specific repetitive way
- ◻ ■ Lifting 50+ pounds
- ◻ ■ Lifting repetitively
- ◻ ■ Operating heavy equipment
- ◻ ■ Other:

General Activity

Daily Living / Self Care Activities
- ◻ ■ Perform all activities alone
- ◻ ■ Require some assistance
- ◻ ■ Need help for some activities
- ◻ ■ Need help for all activities

Activities Outside The Home
- ◻ ■ Often active with others outside home
- ◻ ■ Occasionally active outside home
- ◻ ■ Rarely active outside home
- ◻ ■ Need help for activities outside home

Exercise Physical Activities

Frequency
- ◻ ■ 5+ days per week
- ◻ ■ 3-4 days per week
- ◻ ■ 1-2 days per week
- ◻ ■ Rarely
- ◻ ■ Never

Work Related Physical Activities

Your Sports & Recreational Activities
- ◻ ■ Walking
- ◻ ■ Aerobics
- ◻ ■ Biking
- ◻ ■ Swimming
- ◻ ■ Other:
- ◻ ■ Weight Lifting
- ◻ ■ Running
- ◻ ■ Stationary Biking
- ◻ ■ Stretching/Yoga/Pilates

Diagnostic Tests

Test	Where	When	Results
◻ X-Rays			
◻ MRI			
◻ CT Scan			
◻ Bone Scan			
◻ Arthrogram			
◻ EMG			
◻ Other:			

Prescriptions & Over the Counter Medications List all pills, injections, patches, vitamins, minerals, supplements, herbs.

Name (Example: Tylenol)	Dosage (Example: "500 mg")	Frequency (Example: "Every 4 hrs")	Administration (example: "orally")

Height: ________ Weight: ______________ BMI Score:* ______________ *Clinician will complete the score

Your Initials: ______________________ Reviewing Clinician's Initials: ______________________

Date Completed: ______________________ Date Reviewed: ______________________

FUNCTIONAL STATUS QUESTIONNAIRE

(Adapted/modified from Duffy-Rath Questionnaire)

For each of the following areas, select one of the 10 ratings on the continuum that best describes your ability TODAY.

Rating 1 = Completely Able To Do • Rating 5 = Half Able • Rating 10 = Completely Unable To Do

If a particular area does not apply to you, choose "Not Applicable" (shown below as N/A). For the first 4 areas, also complete the questions relate to pain frequency.

PATIENT NAME ______________________

COMPLETELY ABLE TO DO — SOMEWHAT ABLE — UNABLE TO DO

RATE YOUR ABILITY TO…	N/A	1	2	3	4	5	6	7	8	9	10
1. **Sit** How long can you sit prior to pain? _____ minutes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. **Stand** How long can you stand prior to pain? _____ minutes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. **Walk** How long can you walk prior to pain? _____ minutes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. **Sleep** How often to you wake due to pain? _____ times/night	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. **Bend Forward**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. **Lift and Carry**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. **Participate in Community/Recreational Activities**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. **Work / Do Usual Chores**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. **Have Sexual Relations**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. **Perform Your Normal Daily Activities**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Your Initials: ______________________ Reviewing Clinician's Initials: ______________________

Date Completed: ______________________ Date Reviewed: ______________________

CLINICIAN NOTES ONLY – DO NOT WRITE BELOW THIS SPACE

Functional Status

Score: __________ Out of 100%

When a patient selects N/A, adjust how you calculate the score. If the patient scored 40 points, but only rated their ability for 8 questions, they'd score 50%.

Reference Scale

0%	**CH**
0% (1-19)	**CI**
20% (20-39)	**CJ**
40% (40-59)	**CK**
60% (60-79)	**CL**
80% (80-99)	**CM**
100%	**CN**

Additional Notes

Functionality Codes

- ☐ G8990 Current: ______________
- ☐ G8991 Projected: ______________
- ☐ G8992 Discharge: ______________
- ☐ G8539 Functional Outcome Assessment & Care Plan Documented
- ☐ G8730 Pain Assessed as Positive (1-10/10)
- ☐ G8731 Pain Assessed as Negative (0/10)
- ☐ 3288F **Falls Risk Assessment** documented
- ☐ 0518F Falls **Plan of Care** documented
- ☐ 1100F Patient screened for future fall risk; documentation of **2 or more falls** in the past year or **any fall with an injury** in past year
- ☐ 1101F Patient screened for future fall risk; documentation of **no** falls in the past year or only **one fall without** injury in the past year
- ☐ G8427 Current Medications list **obtained,** updated, reviewed, and documented
- ☐ G8428 Current Medications list **not** documented as obtained/updated/reviewed
- ☐ G8420 BMI Normal (**18-64yo:** BMI 18.5-25**; >65yo:** BMI= 23-30)
- ☐ G8417 BMI **Above** Normal
- ☐ G8418 BMI **Below** Normal
- ☐ G8422 BMI not calculated Pt Not Eligible/Appropriate

☐ **AUTHORIZATION TO RECEIVE A COMPLIMENTARY CONSULTATION**

I, the undersigned, agree to a Complimentary Consultation at BODYWORKS. I understand that this Consultation is not a substitute for an Evaluation and is provided to me as a professional courtesy. By initialing below, I acknowledge this fact and give the therapist permission to perform a physical screening examination and, if needed, advise me on a plan of treatment. Neither I, nor my insurance company, will be billed for this service.

Initials: ________________ Date: ________

☐ **AUTHORIZATION TO RECEIVE AN EVALUATION**

I, the undersigned, agree to an Evaluation at BODYWORKS. I understand that the Evaluation will determine my diagnosis, prognosis, and outcome of treatment. By returning for subsequent appointments, I demonstrate my authorization to receive and participate in a treatment program in accordance with the facility operating policies, which are available for review at my request. Initials: ________________ Date: ________

☐ **ACKNOWLEDGMENT OF HIPAA (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT) REGULATIONS**

I, the undersigned, am aware of the HIPAA provisions that protect the privacy of my medical information and records. I acknowledge that I am aware a written summary of these provisions is available for my review and that, in general, any information about my health care, or payment for that care is considered confidential and protected by BODYWORKS' practice which is consistent with the HIPAA Act of 1996 with regard to Protected Health Information (PHI).

BODYWORKS' Notice of Privacy Practices provides a more complete description of permitted uses and disclosures. BODYWORKS will accommodate any reasonable request for restricted communications. All communication will be routed as verified by me during the consultation/evaluation/orientation and insurance verification process as unless otherwise indicated by me on a separate *Request for Restricted Communications Form*.

Initials: ________________ Date: ________

☐ **AUTHORIZATION TO RELEASE MEDICAL INFO TO HEALTH CARE PROVIDERS INVOLVED IN YOUR TREATMENT**

I, the undersigned, hereby authorize BODYWORKS to release/receive pertinent records – on paper, in electronic form, or verbally – and information regarding my condition, such as: history, physical condition, authorizations, insurance billing and treatment rendered, to/from other health care professionals or organizations involved in my care or payment of care. I understand that purpose of electronic communications in the form of email or other information technology is to allow more rapid action and decision-making to assist in my care.

Initials: ________________ Date: ________

☐ **AUTHORIZATION TO ASSIGNMENT OF BENEFITS AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY**

I, the undersigned, have medical insurance coverage and assign directly to BODYWORKS/PRAXIS CORPORATION medical benefits, if any, payable to me for services rendered. I understand that I am responsible for all charges whether paid for by my insurance or not. I authorize the release of only pertinent medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. In addition, I understand that PRAXIS Corporation reserves the Right to Recover attorney fees and costs associated with the collection of my account in the event that my account is placed with a collection agency to recover the balance due.

Initials: ________________ Date: ________

Patient/Claimant Signature: ____________________________ Date: ________

Legally Authorized Representative: ____________________________ Date: ________

Signature of Witness: ____________________________ Date: ________

Note: The above authorizations will be in effect unless revoked by written notification from the patient.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE

I understand that:

- In general, any information that is about your health and the care you receive or payment for that care is considered confidential and protected by our practice consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with regard to Protected Health Information (PHI).

- BODYWORKS needs to use your protected health information to carry out treatment, payment, health care operations, and/or other purposes. My signature below authorizes the release of pertinent medical records and information – on paper, in electronic form, or verbally.

- BODYWORKS' Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.
  A copy of BODYWORKS' Notice of Privacy Practices has been made available to me.

- PRAXIS CORPORATION will accommodate all reasonable requests for confidential communications. All communications will be routed to me using the information I verified on my Patient Referral Form.
  Are you requesting restricted communications? If so, please complete the Request for Restricted Communications form.

Patient Name: (Please print.) ______________________________

Patient Signature: (OR, below) ______________________________ Date: ____________

Patient Representative/Signature: ______________________________ Date: ____________

Relationship To Patient: ______________________________