

INTAKE INFORMATION

DATE _____ PHYSICIAN WHO REFERRED _____

NAME _____ RECOMMENDED BY _____

COMPLETE ADDRESS _____

HOME PHONE () _____ CELL PHONE() _____

EMAIL ADDRESS _____

SS# _____ DATE OF BIRTH _____

HEIGHT _____ WEIGHT _____ MARITAL STATUS _____

OCCUPATION/EMPLOYER _____

WORK PHONE () _____

SPOUSE'S NAME _____ SS# _____ DOB _____

SPOUSE'S EMPLOYER _____

DATE INJURY/SYMPTOM APPEARS _____

INSURED PARTY _____ DATE OF BIRTH _____ SS# _____

ADDRESS (IF DIFFERENT) _____

PHONE () _____

INSURANCE COMPANY/ADDRESS _____

PHONE NUMBER/CONTACT NAME _____

GROUP NUMBER/POLICY NUMBER/FILE NUMBER _____

IN CASE OF EMERGENCY, CONTACT NAME & PHONE _____

PRIMARY CARE PHYSICIAN NAME/NUMBER _____

BRIEFLY DESCRIBE YOUR SYMPTOMS _____

HAVE YOU HAD EPISODES LIKE THIS BEFORE? _____

RESULT OF AUTO ACCIDENT? _____ JOB INJURY? _____

ADDITIONAL COMMENTS: _____

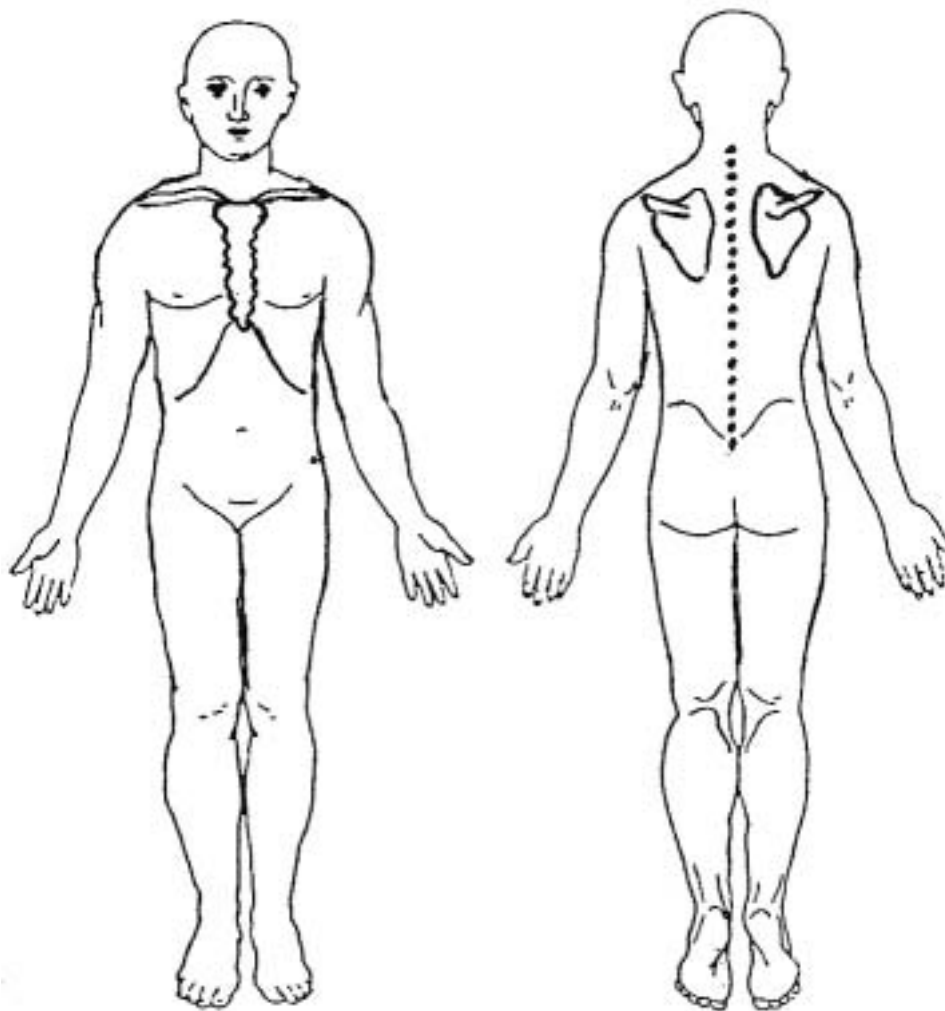
I Intake Information

NAME: _____

DATE: _____

A Pain Drawing

Please mark on the drawings below the areas where you feel pain.



B Pain Intensity

Using the scale from 0 to 10, 0 indicating no pain and 10 indicating worst possible pain:

1.) Circle the level of pain you are feeling now.

0 1 2 3 4 5 6 7 8 9 10

2.) Circle your greatest level of pain.

0 1 2 3 4 5 6 7 8 9 10

C. Present Medication Intake

Type	Dosage	Frequency	For How Long
1.) _____	_____	_____	_____
2.) _____	_____	_____	_____
3.) _____	_____	_____	_____
4.) _____	_____	_____	_____
5.) _____	_____	_____	_____
6.) _____	_____	_____	_____

D. Nutritional Supplement Intake

Type	Dosage	Frequency	For How Long
1.) _____	_____	_____	_____
2.) _____	_____	_____	_____
3.) _____	_____	_____	_____
4.) _____	_____	_____	_____
5.) _____	_____	_____	_____
6.) _____	_____	_____	_____

For questionnaires F and G fill out the form(s) that are relevant to you.

E. Oswestry Low Back Pain Questionnaire

Total Score _____

Please mark only 1 box in each section which most closely describes your ability to manage in every day life.

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.

Personal Care (eg, Washing, Dressing)

- 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.

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.

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.

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 for more than 1 hour.
- 3 Pain prevents me from sitting for more than ½ hour.
- 4 Pain prevents me from sitting for more than 10 minutes
- 5 Pain prevents me from sitting at all.

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 ½ hour.
- 4 Pain prevents me from standing more than 10 minutes.
- 5 Pain prevents me from standing at all.

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 hours.
- 5 Pain prevents me from sleeping at all.

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.

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 under ½ hour.
- 5 My pain prevents all travel except for visits to the Physician/ therapist or hospital.

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.

For questionnaires F and G fill out the form(s) that are relevant to you.

F.

The Neck Disability Index

Patient name: _____ Date: _____

Please read instructions:

This questionnaire provides information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 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 worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

- [0] I can look after myself normally, without causing 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 do not get dressed; I wash with difficult and stay in bed.

SECTION 3-LIFTING

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

SECTION 4-READING

- [0] I can read as much as I want to, with no pain in my neck.
- [1] I can read as much as I want to, with slight pain in my neck.
- [2] I can read as much as I want to, with moderate pain in my neck.
- [3] I can't read as much as I want, because of moderate pain in my neck.
- [4] I can hardly read at all, because of severe pain in my neck.
- [5] I cannot read at all.

SECTION 5-HEADACHES

- [0] I have no headaches at all.
- [1] I have slight headaches that come infrequently.
- [2] I have moderate headaches that come infrequently.
- [3] I have moderate headaches that come frequently.
- [4] I have severe headaches that come frequently.
- [5] I have headaches almost all the time.

SECTION 6-CONCENTRATION

- [0] I can concentrate fully when I want to, with no difficulty.
- [1] I can concentrate fully when I want to, with slight difficulty.
- [2] I have a fair degree of difficulty in concentrating when I want to.
- [3] I have a lot of difficulty in concentrating when I want to.
- [4] I have a great deal of difficulty in concentrating when I want to.
- [5] I cannot concentrate at all.

SECTION 7-WORK

- [0] I can do as much work as I want to.
- [1] I can 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 work at all.
- [5] I can't do any work at all.

SECTION 8-DRIVING

- [0] I can drive my car without any neck pain.
- [1] I can drive my car as long as I want, with slight pain in my neck.
- [2] I can drive my car as long as I want, with moderate pain in my neck.
- [3] I can't drive my car as long as I want, because of moderate pain in my neck.
- [4] I can hardly drive at all, because of severe pain in my neck.
- [5] I can't drive my car at all.

SECTION 9-SLEEPING

- [0] I have no trouble sleeping.
- [1] My sleep is slightly disturbed (less than 1 hr sleepless).
- [2] My sleep is mildly disturbed (1-2 hrs sleepless).
- [3] My sleep is moderately disturbed (2-3 hrs sleepless).
- [4] My sleep is greatly disturbed (3-5 hrs sleepless).
- [5] My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

- [0] I am able to engage in all recreation activities, with no neck pain at all.
- [1] I am able to engage in all my recreation activities, with some neck pain.
- [2] I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- [3] I am able to engage in few of my recreation activities, because of pain in my neck.
- [4] I can hardly do any recreation activities, because of pain in my neck.
- [5] I can't do any recreation activities at all.

Total _____

Percent _____

G. Self-Stress Rating Scale

Multiple research studies clearly indicate a relationship between psychosocial variables and stress related events on long and short term outcomes in individuals with musculoskeletal spine pain.¹⁻⁷ Identifying stressful events in the following Self Stress Rating Scale may help in the management of your musculoskeletal pain condition.

Please indicate a numerical value from 1-3 (1 = slightly stressful, 2 = moderately, 3= extremely) stressful events that you are experiencing. Only rate those events that apply to you.

Family/ Social

- Death of spouse/partner
- Death of a loved one/friend (other than spouse/partner)
- Divorce or separation from partner/spouse
- Marriage/engagement
- Conflict with spouse/partner
- Conflict with family members (other than spouse/partner)
- New addition to the family
- Change in family members health
- Change in number of family gatherings
- Son/daughter leaving or returning home
- Change in social activities
- Caretaker – of children
- Caretaker – of family member

Work/School

- Begin new job
- Business re-adjustment
- Retirement
- Begin/Finish school
- Partner begins/stops work or school
- Trouble with boss/colleagues/employees
- Change in work responsibilities

Financial

- Change in financial status
- Financial concerns/Debt

Personal

- Change in living situation/conditions
- Change in lifestyle/habits (diet, exercise, etc.)
- Change in sleep patterns
- Sexual difficulties
- Trouble finding time to do the things you want to do
- Multi-tasking – taking on too much at once
- Involved in a lawsuit
- Drug and/or alcohol dependency

Other Please list and rate (1–3) other stressors that you are experiencing, not listed above:

Total combined score: _____ / 90 **Percentage of total:** _____

**Atlanta Back Clinic
Orthopedic
Physical Therapy and Training Center**

Financial Policy

Patients are responsible for all indebtedness to the clinic. We strongly recommend that you establish the limits of coverage with your insurance plan prior to beginning treatment. Some insurance companies have ceilings on physical therapy reimbursement with respect to the number of visits or total dollar amount. Other insurance plans only reimburse certain procedures. Most plans do not reimburse for equipment needed for home use.

Payments are accepted in the form of cash, check or credit card (Mastercard or Visa) at the time of the office visit.

Please cancel appointments with at least 4 hours notice or you will incur an appointment charge of \$50.

Signature _____ Date _____

AUTHORIZATION

AUTHORIZATION TO RELEASE INFORMATION: I hereby, authorize the ATLANTA BACK CLINIC to release any information acquired in the course of my examination and treatment to:

PHYSICIAN(S):

Name	Address	Phone
_____	_____	_____
_____	_____	_____

INSURANCE(S):

Name	Address	Phone
_____	_____	_____
_____	_____	_____

ATTORNEY:

Name	Address	Phone
_____	_____	_____

_____	_____
Date	Signature

AUTHORIZATION

AUTHORIZATION TO PAY BENEFITS: I, hereby, authorize payment directly to the ATLANTA BACK CLINIC of all medical benefits, otherwise payable to me for the services rendered as described. I understand that I am fully responsible to the ATLANTA BACK CLINIC for all charges for said services regardless of insurance coverage. If third party payment is not received within a period of 60 days following filing of claim(s), I agree to see that payment is made on the unpaid balance in full or in an amount previously agreed upon.

_____	_____
Date	Signature

**Atlanta Back Clinic
Physical Therapy and Training Center**

Waiver for Supplies

Please be advised that we may submit your claims for the provided supplies or equipment, but that most plans do not reimburse for equipment needed for home use.

Patients are ultimately responsible for the price of any said supply that is submitted and not paid for by your insurance.

Payments are accepted in the form of cash, check, or credit card (Mastercard, Discover or Visa) at the time of the office visit.

Signature _____ Date _____

CONTACT INFORMATION AND HOW TO REPORT PRIVACY RIGHTS VIOLATION

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officers at:

Address: 2191 Northlake Parkway
Tucker, GA 30084
Attn: Privacy Officer
Telephone: 770-491-6004
Fax: 770-723-0872
E-mail: www.atlantabackclinic.com

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts of omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The Effective Date of this Privacy Notice is _____, 200__.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE

Printed Name of Patient **Date**

Signature of Patient or Patient's Representative

Printed Name of Patient's Representative (if applicable)

Representative's Relationship to Patient (if applicable)

=====

To be completed by [Health Care Provider]:

After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s)

Signature of [Health Care Provider] Representative **Date**
