

CAPITAL PHYSICAL THERAPY, PLLC

Shoulder Initial Questionnaire

Your Name: _____ Date: _____

Referring Physician: _____ Sex: _____ Age: _____ Weight: _____

Sports/Hobbies: _____

Occupation: _____ Does occupation include manual labor: _____

Information in regards to your injury

Date of injury: _____ Date of surgery (if indicated): _____

What happened? _____

Is this your first episode of shoulder injury? _____

Previous treatment for this included: _____

Do you have a history of neck injury? _____

Does your injury limit self care or the care to others? _____

Was your shoulder functioning normally before the injury?(if not, please explain) _____

Does your past medical history include any of the following?

	Yes	No	N/A	
1. Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____
2. Any unexplained weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Any weight gain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Headaches or Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. History of Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____
8. History of Cancer in the Family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. History of shoulder surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Any implanted devices such as a pacemaker or an artificial joint?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____
12. Do you suffer from depression due to your illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Psychiatric illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. High/low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. History of neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Decreased circulation in forearm/hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Other? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Information in regards to your medication

List your medications here

Information in regards to your pain

0= Pain free 2= Discomfort 4-6= Moderate 8= Severe 10= Excruciating

1. Please circle the **worst** pain you have experienced during the past week:

0	2	4	6	8	10
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2. Please circle your **current** pain:

0	2	4	6	8	10
---	---	---	---	---	----
3. Please circle the **least** pain you have experienced during the past week:

0	2	4	6	8	10
---	---	---	---	---	----
4. Please circle the **duration** of your pain:

1= Brief	2= Intermittent	3= Constant
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5. Please circle your **medication** use:

1= None	2= Occasional/as needed	3= Constant
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6. Have you experienced any **numbness and tingling** this past week:

1=Yes	2=No	If yes where? _____
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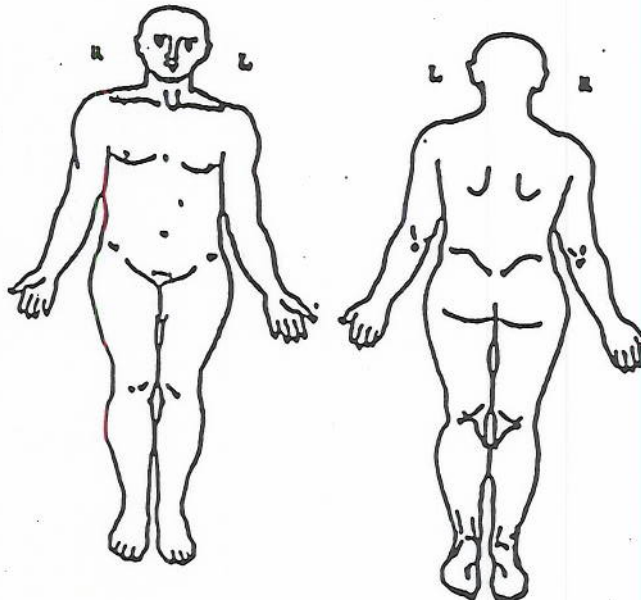
a. Prescription b. Over the counter
7. Have you experienced any **night pain** this past week:

1=Yes	2=No	If yes where? _____
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The location of your pain and other symptoms

Please mark your pain on the diagram on the right:

- *= Pain
- ◆= Numbness/Tingling
- ↓ = Shooting pain
- ↔= Pulsing/beating or throbbing pain



Information in regards to your daily functioning (please circle)

1. Able without difficulty 2. Able with some limitation 3. Difficult 4. Very difficult 5. Unable

With the injuries arm can you?

1. Open a door?	1	2	3	4	5	N/A
2. Touch your low back and buttock?	1	2	3	4	5	N/A
3. Touch the back of your neck?	1	2	3	4	5	N/A
4. Brush teeth?	1	2	3	4	5	N/A
5. Comb hair?	1	2	3	4	5	N/A
6. Get dressed?	1	2	3	4	5	N/A
7. Wipe after a bowl movement?	1	2	3	4	5	N/A
8. Raise your arm to shoulder height?	1	2	3	4	5	N/A
9. Raise your arm over your head?	1	2	3	4	5	N/A
10. Lift a filled cup or glass?	1	2	3	4	5	N/A
11. Lift full-sized pan from the stove?	1	2	3	4	5	N/A
12. Lift groceries into a shopping cart?	1	2	3	4	5	N/A
13. Prepare your own meal?	1	2	3	4	5	N/A
14. Do your own laundry? (including hanging it)	1	2	3	4	5	N/A
15. Perform work duties with ease	1	2	3	4	5	N/A

Which activities ease your pain? _____

Which activities increase your pain the most? _____

Since the injury the pain has become? Worse The same Better

Information in regards to special tests

Did you undergo any of the following tests? (1=Yes, 2=No,3=Don't know)

M.R.I:	_____	Bone Scan:	_____	Do you know the outcome of these studies?
Cat Scan:	_____	E.M.G	_____	_____
X-ray:	_____			_____

Signature: _____ **Date:** _____

CAPITAL PHYSICAL THERAPY, PLLC

PATIENT INFORMATION

Date: _____

Patient: _____

Address: _____

City _____ State _____ Zip _____

Home phone: _____

Male ___ Female ___ Age ___ D.O.B. _____

Married ___ Single ___ Widowed ___

Patient Social Security: _____

Occupation: _____

Employer: _____

Spouse's Name: _____

Birthdate: _____

Occupation: _____

Spouse's employer: _____

Family Physician: _____

Referring Physician: _____

Referring Physician's phone: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____

Relationship: _____

Phone: _____

INSURANCE INFORMATION

Responsible party: _____

Relationship to patient: _____

Birthdate: _____

Primary Insurance: _____

Subscriber's Number: _____

Group Number: _____

Secondary Insurance: _____

Subscribers Name: _____

Birthdate: _____

Relationship to patient: _____

Subscribers Number: _____

Group Number: _____

Auto Insurance: _____

Claim Number: _____

Claims Adjuster: _____

Workman's Comp. Case #: _____

Case Worker: _____

Release of Information and Assignment of Benefits:

I hereby give my consent for an evaluation and treatment by Capital Physical Therapy, PLLC staff. I give permission for Capital Physical Therapy, PLLC to obtain my medical records. I authorize the release of any medical or other information relating to all claims for benefits submitted on my behalf. I permit a copy of this authorization to be used in place of the original. I request payment to be made on my behalf to Capital Physical Therapy, PLLC.

Patient's Signature

Signature of Parent/Guardian (if patient is a minor)

CAPITAL PHYSICAL THERAPY, PLLC

FINANCIAL POLICY

THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY THAT ALL PATIENTS ARE REQUIRED TO READ AND SIGN BEFORE TREATMENT.

REGARDING INSURANCE:

AS A COURTESY TO OUR PATIENTS WE WILL GLADLY BILL YOUR INSURANCE COMPANY. PROVIDED WE HAVE COMPLETE PATIENT AND INSURANCE INFORMATION. WE DO PARTICIPATE WITH MEDICARE AND OTHER PRIVATE INSURANCES. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THIS CONTRACT. THEREFORE, UNDER ANY CIRCUMSTANCES, YOU THE PATIENT ASSUME FINANCIAL RESPONSIBILITY FOR YOUR ACCOUNT.

DEDUCTIBLES AND CO-PAYS

UPON YOUR FIRST VISIT TO CAPITAL PHYSICAL THERAPY, PLLC. OUR PATIENT ACCOUNTS MANAGER WILL VERIFY YOUR COVERAGE AND ANY DEDUCTIBLE AND CO-PAYMENT REQUIREMENTS. PLEASE UNDERSTANDING THAT INSURANCE VERIFICATION IS NOT A GUARANTEE OF PAYMENT AND SOME OR ALL OF YOUR TREATMENT MAY NOT BE COVERED UNDER YOUR POLICY. IT IS OUR POLICY TO COLLECT ALL DEDUCTIBLE AND CO-PAYMENT AMOUNTS AT THE TIME OF SERVICE. FOR YOUR CONVIENCE WE ACCEPT PERSONAL CHECK FOR PAYMENT. PLEASE NOTE THAT FINANCE CHARGES IN THE AMOUNT OF 18% (1.5% MONTHLY) WILL BE ASSESSED ON UNPAID BALANCES AFTER 30 DAYS.

ATTENDANCE:

PLEASE BE AWARE THAT ATTENDANCE IS IMPORTANT THEREFORE, IF THREE ABSENCES OCCUR WITH OUT A CALL TO INFORM US OF THE REASON FOR NOT ATTENDING THE SESSION IT WILL BE OUR UNDERSTANDING THAT YOU ARE NOT INTERESTED IN ATTENDING PHYSICAL THERAPY ANY LONGER. IF YOU WISH TO RESUME AGAIN A NEW REFERRAL SCRIPT WILL BE NEEDED FROM REFERRING DOCTOR AT TIME OF RE-START VISIT.

THANK YOU FOR READING AND UNDERSTANDING OUR FINANCIAL POLICY. IF YOU HAVE ANY QUESTIONS OR CONCERNS PLEASE ASK TO SPEAK WITH OUR OFFICE COODINATOR.

I UNDERSTAND AND AGREE TO THE ABOVE STATED FINANCIAL POLICY.

X

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE: _____