First Coast REHABILITATION
where patient care comes first

MEDICAL HISTORY

Patient Name:	Age:	Date:

How did you hear about First Coast Rehabilitation? _____

Have you previously received services from First Coast Rehabilitation? ☐ Yes ☐ No

Please state your diagnosis as told to you by your physician: _____

Have you ever, or are you presently being treated for any of the following problems?
PLEASE CHECK THE APPROPRIATE BOX.

Heart Trouble	Yes ☐	No ☐	Emphysema	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Back Injury	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Headaches	Yes ☐	No ☐	Bleeding Disorder	Yes ☐	No ☐
Dizziness	Yes ☐	No ☐	Fracture	Yes ☐	No ☐
Fainting Spells	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Pacemaker	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Metalology (implants)	Yes ☐	No ☐
Pregnancy	Yes ☐	No ☐	Respiratory Problems	Yes ☐	No ☐
Seizures	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Allergies	Yes ☐	No ☐
Pelvic Pain	Yes ☐	No ☐	Other		
If so, what?					

Date of injury: _____ How did the injury occur: _____

Have you been hospitalized for the present problem? Yes ☐ No ☐ If so, when? _____

Have you had surgery for the present problem? Yes ☐ No ☐ If so, when? _____

Have you received previous treatment for this problem? Yes ☐ No ☐ If so, when? _____

If yes, please summarize the results: _____

Is there currently any other health, medical, or chiropractic services being rendered to you by any other agency, organization or individual, including home health? Yes ☐ No ☐

If yes, please explain: _____

Last seen by Physician (Date): _____ Next appointment with Physician: _____

Are you on any medications? Yes ☐ No ☐ If yes, please state TYPE of medication: _____

Have you ever had any of the following (check all that apply):

☐ EMG ☐ CAT SCAN ☐ MYELOGRAM ☐ X-RAY ☐ MRI

Have you ever received Physical Therapy, Occupational Therapy, or Speech Therapy services elsewhere?

Yes ☐ No ☐ If yes, where, when, and why: _____

I believe the above to be true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

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I have been informed and acknowledge that participation in physical exercise involving flexibility, strength, balance, agility and aerobic exercise, including the use of equipment and devices, is potentially hazardous activity. I hereby accept the responsibility for any harm, injury or damage that may result from participation in any testing or training conducted. I hereby absolve and hold harmless First Coast Rehabilitation its officers, employees, and affiliates for any claim arising out of any injury to me, whether the result of negligence or any cause. I voluntarily and knowingly acknowledge, accept and assume these risks. I agree that my participation is strictly voluntary and I am personally responsible for my safety and informing my therapist of any change in my condition. Your therapist will be available to answer any questions or concerns you may have regarding your participation, activities, and safety. You have the right to decline any portion of your treatment at any time before or during your treatment session. I allow First Coast Rehabilitation to use my testimonials, videos or photography of me for publication.

Insurance policies are quite varied; it is your responsibility to familiarize yourself with you benefits. It is important to realize that regardless of your insurance coverage, it is the patient who is ultimately responsible for payment of services. We will attempt to accommodate your insurance needs. However, if payment is denied, you will be held responsible for charges you incurred. If you have an unmet deductible, you will be required to pay for services rendered in full until deductible is met.

Payments are generally accepted in the form of cash, check or credit card. Please make all checks payable to First Coast Rehabilitation. For any returned checks, the patient will be charged a $30.00 fee. In the event of default payment your account may be turned over to a collection agency, which may require disclosure of confidential information. If your account is delinquent beyond 30 days, you may be assessed a delinquency fee of 30% of the balance.

Patient's Name (Print)	Date
Patient's Signature	Date
Legal Guardian Signature	Date
Witness	Date

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 by circling a number.

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, recreational 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**

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

DAILY VOIDING LOG

Name:
Date:

Time of Day	Type & Amount Of Food & Fluid Intake	Amount Voided Ounces, S/M/L or Seconds	Amount of Leakage S/M/L	Was Usage Present 1/2/3	Activity With Leakage
Midnight					
1:00 AM					
2:00 AM					
3:00 AM					
4:00 AM					
5:00 AM					
6:00 AM					
7:00 AM					
8:00 AM					
9:00 AM					
10:00 AM					
11:00 AM					
Noon					
1:00 PM					
2:00 PM					
3:00 PM					
4:00 PM					
5:00 PM					
6:00 PM					
7:00 PM					
8:00 PM					
9:00pm					
10:00 PM					
11:00 PM					

Comments:

Number of pads used today:

Pelvic Floor Impact Questionnaire – short form 7

Instructions: Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an **X** in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months**. Please be sure to mark an answer in **all 3 columns** for each question. Thank you for your cooperation.

How do symptoms or conditions related to the following →→→→ usually affect your ↓	***Bladder or urine***	***Bowel or rectum***	***Vagina or Pelvis***
1. ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. emotional health (nervousness, depression, etc.)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Appendix B

Pain Disability Index

In order to determine how effective your treatment is, we need to know how much pain is interfering in your normal activities. For the 7 areas listed below, please circle the number on the scale which describes the level of disability you have experienced in each area OVER THE PAST WEEK. A score of "0" means no disability at all, and a score of "10" indicates that all of the activities which you would normally do have been totally disrupted or prevented by your pain over the past week. Circle "0" if a category does not apply to you.

Family/Home Responsibilities: This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g. yard work, house cleaning) and errands or favors for other family members (e.g. driving the children to school.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Social Activity: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as housewife or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Self-Care: This category includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed).

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Life-Support Activity: This category refers to basic life-supporting behaviors such as eating and sleeping.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Total Score: _____