



53 BRENTWOOD ROAD – SUITE B
BAY SHORE, NEW YORK 11706

Mission Statement

1. Ultra Health Physical and Aquatic Therapy is committed to providing the highest quality health care possible. While working closely with our patients' and referring physicians, we provide the opportunity for various types of procedures and modalities, and we carefully evaluate each patient to determine what will work best for you. We are committed to continuing our education on physical therapy techniques in order to provide our patients with the best care as possible.
2. Our goals are to reduce your pain, increase Range of Motion and Strength, improve your posture, educate you on proper body mechanics, and a home exercise program. After your evaluation, we will send a detailed report stating our findings and our treatment plan to your doctor.
3. It is important to follow your doctor and PT treatment plan if given a home exercise program. You must attempt to do this as this will shorten your therapy treatment and improve your progress. If your prescription says 3x a week, you should come 3x a week. Again, this will help reach your maximum potential.
4. Co-pay must be paid at every visit. Again, if your treatment calls for 3x a week you should come 3x a week. If you can not afford a 3rd co-pay or any co-pay please speak to the receptionist/therapist and we will try to make other arrangements. You should never allow a co-payment to compromise your health. Again, if there is a financial reason, talk to someone.
5. If you ever have any problems, complaints, or suggestions please do not hesitate to speak with me, Edward Kalten PT at [631] 328-5920

Thank you,
Edward Kalten PT, Director



NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information please review it carefully. If you have any questions about this policy you may contact our Privacy Officer, Eddie Kalten.

ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY LEGAL DUTY

It is the legal duty of ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY to protect the confidentiality of your personal health information. We are required to provide you with this notice which outlines our policies and procedures.

USES AND DISCLOSURES OF HEALTH INFORMATION

ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY, hereafter referred to as the Practice, uses your personal health information (PHI) in order to provide treatment to you, to be able to obtain payment for your treatment, to perform administrative activities within the practice, and for being able to determine the quality of care that is provided to you. PHI is all the personal information that can identify you: your name, address, telephone number, social security number, health policy number, etc. For example, we may use your PHI to call you to remind you about an appointment or to contact your insurance company for payment, speak to your Doctor about your program, or just call you into the treatment

The practice may use your PHI without prior authorization when we are required to do so by law, if there is a public health concern, if you have a communicable disease, if we believe that there is abuse or neglect, for research studies, for legal proceedings, for law enforcement, if a crime occurs in the Practice's office, if an emergency occurs, to funeral directors and coroners, for military activity and national security, and for worker's compensation

It is policy of Metro Comprehensive Physical Therapy to get a signed authorization from you prior to releasing your PHI. You have the right to either agree or object to the release of your information. If you agree and sign a written authorization, you have the right to take back the authorization at a later date if you choose to. If you are not actually present, or unable to agree or disagree, to the disclosure of information, the Practice can then use it's professional judgment to decide if the disclosure is in your best interest.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to inspect and ask for a copy of your personal health information at any time. You have the right to ask us to make changes or corrections in your information. The Practice does not have to comply with your request. You have the right to file a disagreement with the Privacy Officer.

You may request a list of all the disclosures that we have made of your PHI after April 14, 2003 for any reason other than for treatment, billing, or administrative activities of the practice.

You also have the right to ask in writing that the Practice not disclose your PHI except when authorized by you, required by law or in the case of an emergency. You may also request that your PHI is not disclosed to family members or friends that may be involved in your care. The Practice will consider all such request, but is not required to agree or act on them. You have the right to have confidential information sent to you at an alternative location or by a means other than the postal service. You have the right to obtain a copy of this notice.

CONCERNS AND COMPLAINTS

If you feel that your privacy rights have been violated at any time or you do not agree with how your PHI is being disclosed, you can contact our Privacy Officer at the address listed below. The Practice will not retaliate against you for filing a complaint. You can also contact the Secretary of Health and Human Services.

**ULTRA HEALTH
PHYSICAL AND AQUATIC THERAPY
53 BRENTWOOD ROAD –Suite B
BAY SHORE, NEW YORK 11706
[631] 328-5920**

The terms of this notice may change at any time. A copy of the revised notice will be posted in the office in easily accessible areas and will be provided to you upon your request. This notice was published on May 1, 2003 and becomes effective on April 14, 2003.

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

53 BRENTWOOD ROAD – SUITE B
BAY SHORE, NEW YORK 11706

Patient Acknowledgement of Receipt of Privacy Practices Notice

This is to acknowledge that I have received and reviewed Ultra Health Physical And Aquatic Therapy's Notice of Privacy Practices. If I have any questions, I can contact the Practice at (631) 328-5920

PRINT NAME: _____

SIGNATURE: _____

DATE: ___/___/___

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

53 BRENTWOOD ROAD – SUITE B
BAY SHORE, NEW YORK 11706

MANAGED CARE TERMS & CONDITIONS FOR PHYSICAL THERAPY

ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY will bill your insurance carrier at our contracted rates. If a co-payment is due you will be responsible for meeting your payment after each visit and please be aware of your insurance policy provisions. I understand that I am responsible for any charges that are not covered by my insurance carrier. If we get denied payment for any reason due to these provisions, you will be responsible to pay us for the denied visits. If you have any questions about which limitation applies to you, please ask the billing department or contact your insurance directly. Furthermore, I understand that I am responsible to inform the office of any changes that occur.

I authorize release of payment directly to ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY regardless of participation in or out-of-network.

I have also advised ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY that my condition being treated is not directly related to work and/or an on the job injury, nor is it due to any motor vehicle accident.

Once your insurance benefits are exhausted, if you wish to continue physical therapy, you will be responsible for our private fee. There will be an increase in fee if additional equipment of these exercise procedures are used; e.g. Cybex, Nautilus, or Eagle. There will be an increase in fee if more than one diagnosis is being treated.

In the event that this account should be placed in the hands of an outside attorney for collection due to the default of my financial responsibility, the Responsible Party agrees to pay all outside costs of collection, including reasonable attorneys' fees not to exceed 20% of the unpaid balance, together with necessary court costs and disbursements.

If you are unable to keep your appointment, please give the office 24 hour cancellation notice. If 24 hour cancellation is consistently not given, we will no longer schedule appointments in advance, and we will ask that you call for your appointment on the same day you would like to come in.

I have read the above and I agree to these Terms & Conditions.

SIGNATURE: _____

DATE: ____/____/____

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

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BAY SHORE, NEW YORK 11706

Notice of Advice

I am aware that my co-pay is _____ per visit.

I am aware that if my insurance requires a referral. I will be responsible to obtain this referral for the visits required.

I am aware of the possibility that physical therapy treatment may not be covered by my health care insurer without the referral of a physician, dentist, podiatrist, or nurse practitioner, but may be a covered expense, if treatment was rendered pursuant to such referral.

I am aware that I am responsible to obtain a new prescription when needed to continue with my physical therapy treatment.

I understand that I am responsible to comply with the Co-pays, referrals, and prescriptions. Failure to do so could result in discontinuation of treatment and payment of any un-paid insurance bills.

Signature: _____

Date: ____/____/____

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

CONFIDENTIAL MEDICAL HISTORY/EVALUATION

Name: [LAST] _____, [FIRST] _____ Date: ____/____/____
Address: _____ Ph:/cell: [____] _____
Emergency Contact _____ Relationship: _____ Ph: [____] _____
Insurance Co: _____ Subscriber ID: _____ Group #: _____
Insured Employer/Address: _____
Occupation: _____ Is this injury: Work Related Y/N Auto Accident Y/N
Date of Injury: _____ Chief Complaint: _____
Current Limitations: _____
List any/all medications you are currently taking: _____
Are you allergic to any medications: _____
List any surgeries: _____
Have you had any diagnostic test for this Injury? MRI Results/Date _____
Other: _____ X-ray Results/Date _____

				Mild	Moderate	Severe	Unable
Asthma, Bronchitis or Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath/Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Care for Infirm Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Carrying Groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Change Pos (Sit to Stand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Climb Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Extended Computer Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot/Emboli	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Feeding (self)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Household Chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Trouble/Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lift Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pet Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or Chemo/Radiation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reading (concentration)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Swollen Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Self Care – Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Self Care – Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Self Care – Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexual Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping Difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional/Psychological Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sitting (prolonged)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel or Bladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Standing (prolonged)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe/Frequent Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision/Hearing Difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Yard Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or Faintness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sports _____				
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recreational Activities _____				
Smoking	Daily _____	Weekly _____	Exercise	Daily _____	Weekly _____		
Alcohol Consumption	Daily _____	Weekly _____					

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim.

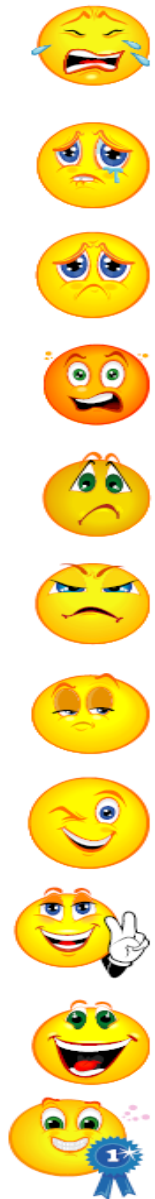
Patient /Parent/Guardian Signature: _____

Date: ____/____/____

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

PAIN ASSESSMENT



10

WORST PAIN POSSIBLE,
UNBEARABLE.
Unable to do any activities due to pain.

9

INTENSE, DREADFUL,
HORRIBLE.
Unable to do most activities because of pain.

8

7

6

MISERABLE, DISTRESSING.
Unable to do some activities due to pain.

5

4

NAGGING PAIN, UNCOMFORTABLE,
TROUBLESOME.
Can do most activities with rest periods.

3

2

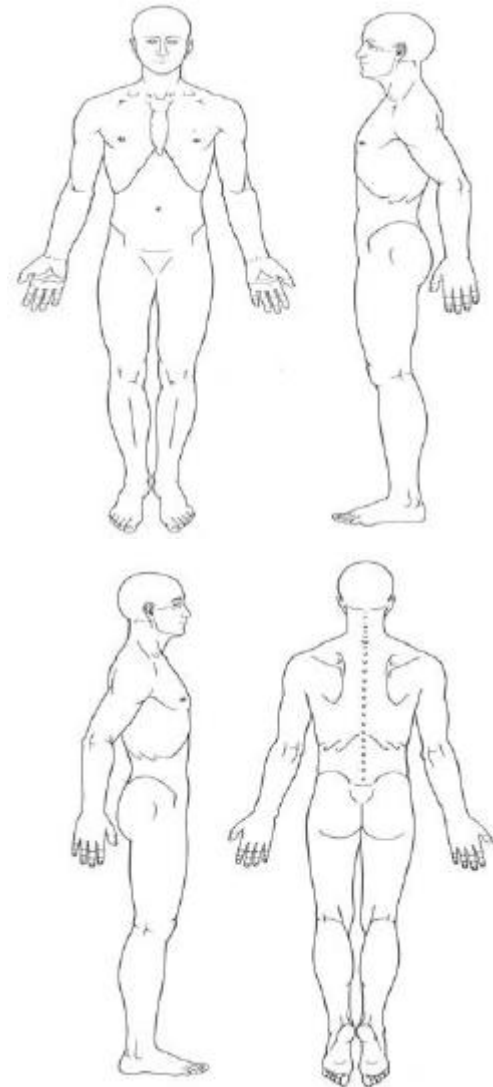
MILD PAIN, ANNOYING.
Pain is present, but does not limit activity

1

0

NO PAIN.

Indicate where you have pain
or other symptoms



PAIN ASSESSMENT LEVEL : PRESENT: ____/10, AT BEST: ____/10, AT WORST : ____/10

1. Describe your symptoms: _____

a. Onset of injury: _____

b. Mechanism of injury : _____

2. How often do you experience your symptoms?

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

Signature: _____ Date: ____/____/____

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

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BAY SHORE, NEW YORK 11706

Aquatic Therapy Screen

CHECK YES OR NO IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS.

- | | Y | N | |
|---|--------------------------|--------------------------|--|
| • | <input type="checkbox"/> | <input type="checkbox"/> | Typhoid, cholera, dysentery, or any other waterborne disease |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Fever higher than 100 Degrees Fahrenheit |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Stomach or intestinal disorder |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Infectious disease |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Open wounds |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Skin rashes |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Perforated Ear Drums |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Incontinence |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment within last 3 months |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| • | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure or heart disease |
| • | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker or Defibrillator |

PRINT NAME _____

SIGNATURE _____

DATE: _____

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

53 BRENTWOOD ROAD – SUITE B
BAY SHORE, NEW YORK 11706

Physical Therapy Consent for Treatment

PROPOSED INTERVENTION/TREATMENT

- | | |
|---|--|
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Bed/transfer mobility |
| <input type="checkbox"/> Gait Training | <input type="checkbox"/> Manual Therapy |
| <input type="checkbox"/> Modalities | <input type="checkbox"/> CPM |
| <input type="checkbox"/> Pool Therapy | <input type="checkbox"/> Wound Care |
| <input type="checkbox"/> Patient Education | <input type="checkbox"/> Other _____ |

POSSIBLE RISK OF HARM/COMPLICATIONS

Therapeutic exercise: sore muscles and joints

Transfers and Gait Training: fall, injury from falls.

Manual Therapy: sore joints and ligaments. Rarely, dislocation, fracture, paralysis or death.

Modalities: rash, burns, skin damage: rare, burning, periosteum.

Pool Therapy: skin irritations; rare-drowning

Wound Care: skin irritations, infection, spread of infection, increased wound size.

Other: _____

ALTERNATIVE TO TREATMENT

- Chiropractic Care
- Acupuncture
- Massage Therapy
- No treatment, resulting in possible decrease in function
- Other: _____

GOAL OF TREATMENT

- Improve mobility
- Improve function
- Improve independence
- Decrease pain
- Other: _____

Physical Therapist **EDDIE KALTEN –PT**

Patient Signature: _____

Date: ____/____/____

PT/OT Treatment Form
(version 1.5)

www.palladianhealth.com/providers



4287

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Section A. Provider information		Specialty: <input type="radio"/> PT <input type="radio"/> OT	Provider ID
		Location: <input type="radio"/> Office <input type="radio"/> Facility	
First name		Service Street Address	
Last name			
Facility name		Check if <input type="radio"/> Workers' compensation injury <input type="radio"/> No-fault injury	

Section B. Patient information		Date of Birth	M M	-	D D	-	Y Y	Y Y
First name		Onset		-		-		
Last name		Last visit		-		-		
Health plan		Requested start		-		-		
Member ID								

Section C. Primary region of complaint (select only 1 region)

Spine	Upper extremity	Lower extremity	Other (also indicate region)	Rehabilitation
<input type="radio"/> Cervical	Shoulder <input type="radio"/> L <input type="radio"/> R	Hip <input type="radio"/> L <input type="radio"/> R	<input type="radio"/> Post-surgical	<input type="radio"/> Stroke
<input type="radio"/> C/S+radiculopathy	Elbow <input type="radio"/> L <input type="radio"/> R	Knee <input type="radio"/> L <input type="radio"/> R	<input type="radio"/> Fracture	<input type="radio"/> Spinal cord
<input type="radio"/> Thoracic	Wrist <input type="radio"/> L <input type="radio"/> R	Ankle <input type="radio"/> L <input type="radio"/> R	<input type="radio"/> Other	<input type="radio"/> Neurological
<input type="radio"/> Lumbosacral	Hand <input type="radio"/> L <input type="radio"/> R	Foot <input type="radio"/> L <input type="radio"/> R		<input type="radio"/> Balance/coordination
<input type="radio"/> L/S+radiculopathy				

Primary ICD-9

Section D. Red flags (i.e. signs or symptoms that may indicate potentially serious pathology)

Does this patient have any red flags (e.g. "yes" answers to PT/OT Patient Intake Form questions 6-20)? No Yes

Does this patient have any contraindications to receiving PT/OT care from you for this complaint? No Yes

Section E. Evaluation

Based on information provided by the patient, your examination, and your treatment history with this patient (if any), what is your evaluation of this patient's primary region of complaint? Please choose one box for each of these columns.

Symptoms	Physical function	Overall health	Prognosis
<input type="radio"/> Very mild	<input type="radio"/> Very good	<input type="radio"/> Very good	<input type="radio"/> Very good
<input type="radio"/> Mild	<input type="radio"/> Good	<input type="radio"/> Good	<input type="radio"/> Good
<input type="radio"/> Moderate	<input type="radio"/> Moderate	<input type="radio"/> Moderate	<input type="radio"/> Moderate
<input type="radio"/> Severe	<input type="radio"/> Poor	<input type="radio"/> Poor	<input type="radio"/> Poor
<input type="radio"/> Very severe	<input type="radio"/> Very poor	<input type="radio"/> Very poor	<input type="radio"/> Very poor

Section F. Management plan (i.e. how you plan on managing this patient's complaint)

Education about:	<input type="radio"/> Diagnosis	<input type="radio"/> Prognosis	<input type="radio"/> Remaining active	<input type="radio"/> Other	<input type="radio"/> None
Home/self-care:	<input type="radio"/> Heat/ice	<input type="radio"/> General exercise	<input type="radio"/> Specific exercises	<input type="radio"/> Other	<input type="radio"/> None
Supervised exercise:	<input type="radio"/> Strengthening	<input type="radio"/> Stretching	<input type="radio"/> Stabilization	<input type="radio"/> Other	<input type="radio"/> None
Modalities:	<input type="radio"/> Heat/ice	<input type="radio"/> TENS/EMS	<input type="radio"/> Ultrasound	<input type="radio"/> Other	<input type="radio"/> None
Manual therapy:	<input type="radio"/> Manipulation	<input type="radio"/> Mobilization	<input type="radio"/> Soft tissue	<input type="radio"/> Other	<input type="radio"/> None

Number of PT/OT visits used since last PT/OT Treatment Form was submitted:

0 1 2 3 4 5 6 7 8 9 10 Other

Phone [] [] [] - [] [] [] - [] [] [] Fax [] [] [] - [] [] [] - [] [] []

Provider signature: X Date [] [] / [] [] / [] [] [] []

V:PalladianPTOTreatment(1.5)20100113

4287

Note: By completing and signing this form below, the provider indicates that they:
1. provided/supervised all PT/OT services, and 2. are a participating PT/OT provider, and 3. provided all PT/OT services in a credentialed practice.



17131

Last name	<input type="text"/>	First name	<input type="text"/>
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PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

- Neck
- Shoulder
- Hip
- Stroke rehabilitation
- Other (also indicate region)
- Upper/mid-back
- Elbow
- Knee
- Spinal cord rehabilitation
- Post-surgical
- Lower back
- Wrist
- Ankle
- Neurologic rehabilitation
- Fracture
- Hand
- Foot
- Balance/coordination
- Other

2. When did this problem first begin?

- Less than 1 month ago
- 1-3 months ago
- 4-6 months ago
- 7-12 months ago
- More than 1 year ago

Has this problem...

No Yes

3. ... resulted from a work injury (i.e. workers' compensation insurance claim)?

4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)?

5. ... recently been evaluated by a medical doctor?

Since this problem began, have you noticed...

No Yes

6. ... so much weakness in both your arms that you are unable to lift them?

7. ... so much weakness in both your legs that you are unable to walk without help?

8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate?

9. ... pain in your chest, shortness of breath, or coughing up blood?

10. ... that one leg felt more warm, more swollen, more red, or more tender than the other?

Have you recently...

No Yes

11. ... had blurred vision, double vision, dizziness, or fainting?

12. ... had any type of infection, fever, or chills?

13. ... had any type of surgery, surgical procedure, or medical procedure?

14. ... lost a lot of weight without really trying to (i.e without being on a diet)?

15. ... had any type of accident, fall, or trauma?

Have you ever...

No Yes

16. ... been diagnosed with cancer?

17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?

18. ... been diagnosed with a weakened immune system?

19. ... used any injected drugs (i.e. non-prescription drugs)?

20. ... used steroids such as prednisone for more than 4 weeks?

Is this problem something that ...

No Yes

21. ... you've had before?

22. ... generally gets worse (i.e more severe or frequent) with movement, activity, or exercise?

23. ... generally gets better (i.e. less severe or frequent) with rest?

24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?

25. ... is also being treated by a health professional other than a physical or occupational therapist?

17131



Last Name	<input type="text"/>	First name	<input type="text"/>
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PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Excellent Very good Good Fair Poor

1. In general, would you say your health is

The following questions are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

Yes, limited a lot Yes, limited a little No, not limited at all

3. Climbing several flights of stairs

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like

All of the time Most of the time Some of the time A little of the time None of the time

5. Were limited in the kind of work or other activities

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like

All of the time Most of the time Some of the time A little of the time None of the time

7. Did work or other activities less carefully than usual

8. During the past week, how much did pain interfere with your normal work (including work outside the home and housework)?

Not at all A little bit Moderately Quite a bit Extremely

These questions are about how you feel and how things have been with you during the past week.

For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past week...

All of the time Most of the time Some of the time A little of the time None of the time

9. Have you felt calm and peaceful?

10. Did you have a lot of energy?

11. Have you felt downhearted and depressed?

12. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time Most of the time Some of the time A little of the time None of the time

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

Not severe 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable

13. Right now

14. On average

15. At its best

16. At its worst

