



Arrival Policy

611 E Fairview Ave., Olivia, MN 56277
(p) 320.523.3470 (f) 320.523.3429

In order to receive the maximum benefit from your rehabilitation program, it is important to understand and comply with the following guidelines:

- *Attend all scheduled therapy appointments and follow any home instructions.*
- *Notify the clinic 24 hours prior to your scheduled appointment if you are unable to attend*
- *Inform the front desk staff of upcoming physician appointments or any other scheduling conflicts*
- *In addition, patients may be subject to discharge from therapy services when they fail to arrive to three scheduled appointments.*
- *At times it may be necessary for Big Stone Therapies, Inc. to change or reschedule your therapy appointment(s). By signing this agreement I give consent to allow the staff at Big Stone Therapies, Inc. to contact me by phone, email, at home or work regarding information about my therapy appointment(s) including leaving messages.*

Your compliance with this policy will ensure that we can provide you with the best therapy experience. We look forward to the opportunity to work with you and to help you heal.

I understand and agree to the following policy as stated above.

Patient Signature

Date

We will be communicating with your physician throughout the course of your treatment to keep him/her well informed of your treatment plan and your progress. We take pride in keeping a high level of communication with your health care provider to ensure the highest quality of care.

To better acquaint your therapist with your medical history, you have been asked to complete this health questionnaire. Your answers are strictly confidential and help your therapist perform a detailed evaluation.

Name _____ Height _____ Weight _____

Occupation _____ Full Time or Part Time (circle) Work Restrictions? Yes/No (circle)

What do you do for work activities? _____

What do you do for hobby/leisure/sports activities? _____

How would you rate your general health status? Excellent Good Fair Poor (circle one)

During the past month, have you been bothered by feeling down, depressed, or hopeless? Yes/No (circle)

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes/No (circle)

If yes, is this something with which you would like help? Yes/Yes, but not today/No (circle)

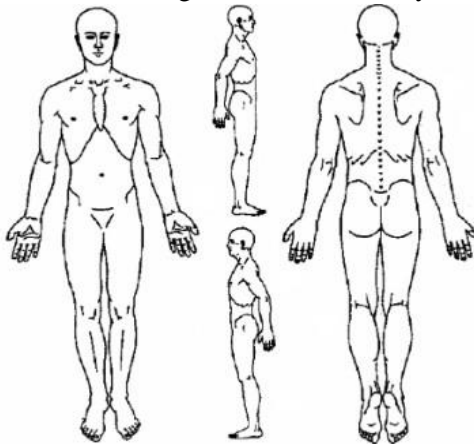
Do you smoke or use tobacco? Yes/No (circle) Do you drink alcohol? Yes/No (circle)

What is your stress level? Low Medium High (circle one)

Would you be interested in learning about a Wellness or weight loss program? Yes/No (circle)

-----Current Symptoms-----

Please mark the area on the diagrams below where your symptoms are:



Please circle the number which best represents the severity of your pain.

At **WORST** the last 24 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

At **BEST** the last 24 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

AVERAGE over the last 24 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Briefly describe current symptoms _____

When and how (gradually or suddenly) did the symptoms start? _____

Do your symptoms completely go away for any period to time? Yes / No (circle)

Are your symptoms worse at any time of the day? Yes / No (circle) If Yes, then when? _____

What makes your symptoms WORSE? (circle all that apply)

Lying down Standing Walking Stress Sitting Other: _____

What makes your symptoms BETTER? (circle all that apply)

Lying down Standing Walking Stress Sitting Other: _____

Currently are you receiving treatment from anyone else for your symptoms? Yes/No (circle)

If yes, please list _____

Have you previously received treatment for symptoms? Yes/No (circle)



Medical History Form

611 E Fairview Avenue, Olivia, MN 56277
(p) 320.523.3470 (f) 320.523.3429

If yes, when and what providers _____

Have you had an x-ray, MRI, or other imaging for this issue? Yes/No (circle)

If yes, please explain _____

Are the symptoms currently: Better Worse Same (circle one)

-----**Medical History**-----

Do you currently have, or have previously, been diagnosed with any of the following conditions? (circle all that apply)

- | | | | | |
|--------------------------------|-----------------------|--------------------------|----------------------|---------------------------|
| Cancer | Heart Problems | Lung Problems | Neurologic Disorders | Diabetes |
| Osteoporosis | Poor Balance | Changes in Appetite | Dizziness/Vertigo | Arthritis |
| Headaches | Thyroid Disease | Nausea/Vomiting | Difficult swallowing | Peripheral Artery Disease |
| Unwanted Bowel or Bladder Loss | Loss of Consciousness | Sensitivity to Cold/Heat | Night Sweats | |

List all prescription and/or over the counter medications recently or currently taking. See attached prescription list.

Did you have any previous surgical history? (circle and date all that apply)

- | | | | |
|------------------------|--------------------|-------------------------|-------------|
| Hospitalizations _____ | Broken Bones _____ | Serious Illnesses _____ | Falls _____ |
| Surgeries _____ | Dislocations _____ | Sprains _____ | Other _____ |

Do you have a family history of any of the following? (circle all that apply)

- | | | | |
|------------------------|----------|------------------------|---------------------------|
| Cancer | Diabetes | Heart Disease | High Blood Pressure |
| Arthritis/Osteoporosis | Stroke | Psychosocial Disorders | Peripheral Artery Disease |
| Other _____ | | | |

Currently I am experiencing (circle all that apply)

- | | | | |
|---|----------------------|-------------------------|--------------------------------------|
| Fever/Chills/Sweats | Poor Balance (Falls) | Unexplained Weight Loss | Numbness or Tingling |
| Changes in Appetite | Depression | Difficulty Swallowing | Recent Bacterial Infection |
| Shortness of Breath | Dizziness | Fatigue | Changes in Bowel or Bladder Function |
| Headaches | Nausea/Vomiting | Increased Pain at Night | Recent Trauma or Accidents |
| Numbness in area that covers a bicycle seat | Urine Retention | Morning Stiffness | |

-----**Personal Information**-----

Do you have any barriers to learning? Yes/No (circle)

If yes, please explain _____

What methods of learning do you prefer? (circle all that apply)

- | | | | | |
|----------|---------------|----------|--------------------|---------------------|
| Handouts | Demonstration | Practice | Verbal Instruction | Written Instruction |
|----------|---------------|----------|--------------------|---------------------|

Identify up to three important functional activities that you are currently unable to do or are having difficulty with:

1. _____
2. _____
3. _____

Please list personal goal(s) for therapy _____



Medical History Form

611 E Fairview Avenue, Olivia, MN 56277
(p) 320.523.3470 (f) 320.523.3429

Patient Signature _____ Date _____

Parent/Guardian signature if patient is under 18 years of age



Upper Extremity Functional Index

Patient Name _____ Date _____

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provide an answer for each activity.

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	Lifting a bag of groceries to waist level	0	1	2	3	4
4	Lifting a bag of groceries above your head	0	1	2	3	4
5	Grooming your hair	0	1	2	3	4
6	Pushing up on your hands (e.g from bathtub or chair)	0	1	2	3	4
7	Preparing food (e.g., peeling, cutting)	0	1	2	3	4
8	Driving	0	1	2	3	4
9	Vacuuming, sweeping or raking	0	1	2	3	4
10	Dressing	0	1	2	3	4
11	Doing up buttons	0	1	2	3	4
12	Using tools or appliances	0	1	2	3	4
13	Opening doors	0	1	2	3	4
14	Cleaning	0	1	2	3	4
15	Tying or lacing shoes	0	1	2	3	4
16	Sleeping	0	1	2	3	4
17	Laundrying clothes (e.g., washing, ironing, folding)	0	1	2	3	4
18	Opening a jar	0	1	2	3	4
19	Throwing a ball	0	1	2	3	4
20	Carrying a small suitcase with your affected limb	0	1	2	3	4
	Column Totals:					

SCORE: _____ / 80