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.

Medical History Form

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

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)

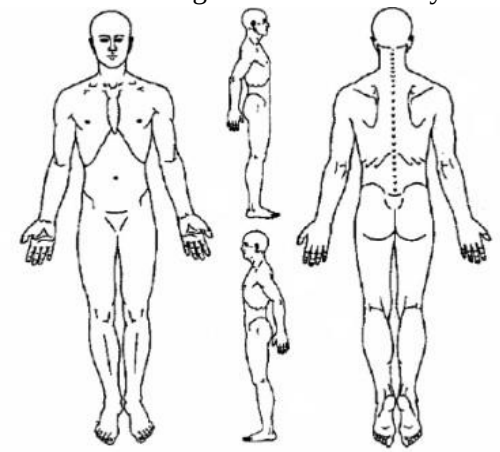
Do you smoke or use tobacco? Yes/No (circle) Do you drink alcohol? Yes/No (circle)

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

Oswestry Disability Questionnaire

Patient Name _____ Date _____

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (e.g. Washing, Dressing)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

Section 3: Lifting

- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, i.e. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything.

Section 4: Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me from walking more than 1 ¼ mile.
- ☐ Pain prevents me from walking more than ¾ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and gives no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sports
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Traveling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to receive treatment

Score _____ / _____ X 100 = _____%

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows

Example: 16(total Scored)
50 (total possible score) X 100=32%

If one section is missed or not applicable the score is calculated:
16 (total scored)
45(total possible score) X 100= 35.5%

Minimum Detectable Change (90% confidence): 10%points (change of less than this may be attributable to error in the measurements

Source: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. Spine, 25 (22): 2940-2953. Davidson M & Keating J (2001) A comparison of five low back disability questionnaires: reliability and responsiveness. Physical Therapy 2002; 82:8-24