

What can your physical therapist help you achieve?

List any medications/ dietary supplements you are taking.
_____ None

List any drug or latex allergies.
_____ None

Do you have difficulties with? (Check all that apply)

- Communication Vision None
 Speech Hearing Other _____

What is your primary language for healthcare?

- English Spanish Other _____

How do you learn best? (Check one)

- Seeing Doing Hearing

Are you: (Check Yes or No)

Pregnant? Potentially Pregnant / Nursing? N/A Y N

Often bothered by feeling down, depressed or hopeless? Yes No

Often bothered by little interest or pleasure in doing things? Yes No

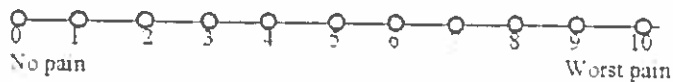
Do you: (Check Yes or No)

Feel safe at home and in the workplace? Yes No

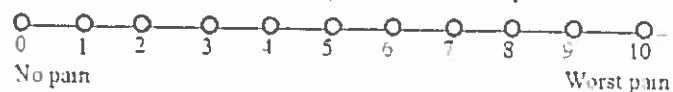
Use tobacco? Yes No
 If yes, type _____, amount per day _____, for _____ years

Use alcohol? Yes No
 If yes, _____ drinks per week

Rate your HIGHEST/WORST pain level in the past 72 hrs.



Rate your LOWEST/BEST pain level in the past 72 hrs.



Are your symptoms:

- Getting worse? Not Changing? Getting Better?

Have you or any immediate family member ever been told you have: (Check Yes or No)

	Self		Family	
Cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatoid Arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you have a history of: (Check Yes or No)

Asthma/Bronchitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain/Angina?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurologic Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoarthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain with sexual intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain in the pelvic region?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexually Transmitted Diseases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prior Surgeries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other _____		

In the past 3 months have you experienced: (Check Yes or No)

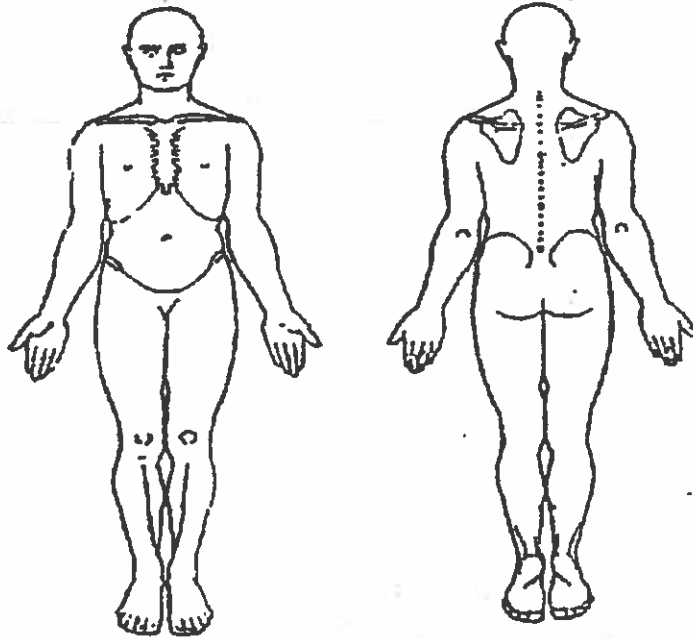
A change in your general health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea/Vomiting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever / Chills / Sweats?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained weight change (>10lbs)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Numbness or Tingling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes in your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty swallowing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes in cough/sputum?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bowel / Bladder loss of control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infections of any sort?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty sleeping due to pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained Falls/Decreased balance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness / Vertigo?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

(Form continued on back side)

PATIENT IDENTIFICATION:

NAME (Last, First MI) _____ GRADE or RANK: _____ UNIT: _____
 Last 4 # of Sponsor's SSN: _____ DOB (MM/DD/YY) _____ PHONE _____

Mark on the body chart below where your pain is located and then describe what it feels like to you.



List 3 activities you have difficulty doing because of your pain.
Then on the scale below each activity, mark how difficult the activity is to perform.
(Example: running 1 mile—8)

Activity #1 _____

<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
No restrictions			Moderate difficulty					Unable to perform		

Activity #2 _____

<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
No restrictions			Moderate difficulty					Unable to perform		

Activity #3 _____

<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
No restrictions			Moderate difficulty					Unable to perform		

RADER PHYSICAL THERAPY

CLINIC POLICY

833-853-1392

Please carefully review the following guidelines concerning your scheduled visits at Andrew Rader USAHC Physical Therapy Clinic. Late cancellations and NO-SHOWS greatly impair our ability to provide the best care possible to our patients, increases wait times, slows each patient's rehabilitation progress and eliminates an appointment that could have been used by another patient. Each no-show costs the Rader PT Clinic approximately \$70. Use your camera phone to take a picture of this sheet with the phone numbers on it.

1. If you cannot make your scheduled appointment, please call the PT Clinic or Central Appointments (855-227-6331) as soon as possible (preferably within 24 hours) of your appointment to **CANCEL**. This allows our team to schedule other patients into that appointment slot. Please be considerate to your fellow patients because an appointment missed by you is an appointment missed by TWO. If you do not contact the clinic prior to scheduled time, the clinic will be consider your failure as a **NO-SHOW**. It is important to ensure that your correct phone number is listed in DEERS.
2. If a patient no-shows 2 or more appointments within a consecutive 30-day period, his/her chain of command may be notified of the missed appointments. We may recommend a negative counseling for the missed appointment using the DA4856 on the back of this sheet. A comment will be placed in the patient's electronic medical record documenting the missed appointments.
3. Patients who **NO-SHOW** on **3** separate occasions without good cause will have future appointments discontinued, their chain of command notified, and may be referred back to their primary care provider. Also patients who **NO-SHOW** will be called and advised that future appointments may be discontinued. Patients may be allowed to schedule additional appointments only at the discretion of the Chief, Physical Therapy.
4. Please be courteous to other scheduled patients and arrive to your appointments on time. If you are more than 10 minutes late, your will be considered an **NO-SHOW** and may be rescheduled at the discretion of the NCOIC and the treatment team given potential conflicts with other established patient's appointments. If you are going to be late, please call the clinic ahead of time so that we can best accommodate you.

I have read and understand the Rader Physical Therapy Clinic Patient policy. Help us help you.

Patient's Signature:_____ **Date:**_____

Patient's Name/Rank/Unit:_____

Patient's Supervisor/1SG Phone # and/or email address:

NECK DISABILITY INDEX¹

Section 1: To be completed by patient

_____ AD

_____ Non-Active Duty

Name: _____

Age: _____

Date: _____

Occupation: _____

Number of days of neck pain: _____ (this episode)

Section 2: To be completed by patient

This questionnaire has been designed to give your therapist information as to how your neck pain has affected your ability to manage in every day life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the line which most closely describes your current condition.**

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.

Personal Care (Washing, Dressing, etc.)

- _____ I do not have to change the way I wash and dress myself to avoid pain.
- _____ I do not normally change the way I wash or dress myself even though it causes some pain.
- _____ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- _____ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- _____ Because of my pain I am partially unable to wash and dress without help.
- _____ Because of my pain I am completely unable to wash or dress without help.

Lifting

- _____ I can lift heavy weights without increased pain.
- _____ I can lift heavy weights but it causes increased pain
- _____ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (ex. on a table, etc.).
- _____ Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
- _____ I can lift only very light weights.
- _____ I can not lift or carry anything at all.

Reading

- _____ I can read as much as I want to with no pain in my neck.
- _____ I can read as much as I want to with slight pain in my neck.
- _____ I can read as much as I want with moderate pain in my neck.
- _____ I can't read as much as I want because of moderate pain in my neck.
- _____ I can hardly read at all because of severe pain in my neck.
- _____ I cannot read at all.

Headache

- _____ I have no headache at all.
- _____ I have slight headaches which come infrequently.
- _____ I have moderate headaches which come infrequently.
- _____ I have moderate headaches which come frequently.
- _____ I have severe headaches which come frequently.
- _____ I have headaches almost all the time.

(Don't forget to fill out the back side)

NECK DISABILITY INDEX, p. 2

Section 2 (con't): To be completed by patient

Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Work

- I can do as much as I want to.
- I can only do my usual work but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleep loss).
- My sleep is mildly disturbed (1-2 hour sleep loss).
- My sleep is moderately disturbed (2-3 hours sleep loss).
- My sleep is greatly disturbed (3-5 hours sleep loss).
- My sleep is completely disturbed (5-7 hours sleep loss).

Recreation

- I am able to engage in all my recreational activities with no neck pain at all.
- I am able to engage in all my recreational activities with some pain in my neck.
- I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I can't do any recreational activities at all.

Section 3: To be completed by physical therapist/provider

SCORE: _____ out of 50 (SEM 5, MDC 7) Initial F/U ___ weeks Discharge
Number of treatment sessions: _____ Gender: Male Female
Diagnosis/ICD-9 Code: _____

¹ Adapted from Vernon H, Mior S. The Neck Disability Index: A Study of Reliability and Validity. Journal of Manipulative and Physiological Therapeutics 1991; 14(7): 409-415.