Align

Center for Integrative Health & Postural Restoration

Provider's:
Mike Cantrell, MPT PRC
James R. Guzman, PTA PRC
Alice Lam, DDS

CONSENT FOR TREATMENT

I ___________________________________, voluntarily give my consent to Align Center for Integrative Health & Postural Restoration to evaluate and treat my condition, including the consent to receive telehealth services. Authorization For Release Of Medical Information for consideration of services rendered by Align Center for Integrative Health & Postural Restoration I hereby guarantee payment of all charges incurred by above named patient. I hereby assume the responsibility of billing and accepting assignment of benefits of my insurance policy to be paid directly to me; the insured for services rendered. I further authorize this office to release/receive any information acquired in the course of my examination and treatment to my insurance company, other physicians, hospital, clinics or Align Center for Integrative Health & Postural Restoration. I authorize Align Center for Integrative Health & Postural Restoration to release information regarding my care/treatment to the following family members (spouse, children, siblings):
____
____

It is the patient's responsibility to keep personal items with them at all times. I also authorize Align Center for Integrative Health & Postural Restoration to photograph me for the purpose of identity in my medical records not to be shared with any outside sources. I understand and authorize that if photos are taken of my injury during the course of treatment, that these photos can be shared with insurance carriers or attorneys if requested to insure payment and/or for educational purposes.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES INCURRED WHILE IN TREATMENT WITH Align Center for Integrative Health & Postural Restoration.

PATIENT NAME (PLEASE PRINT) ____

PATIENT SIGNATURE ____ DATE SIGNED ______________

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PATIENT INFORMATION

Name: (Last) ___________________ (First)________________ (MI)_____ Suffix/Nickname: ___________________

Social Security #: __________________________ Birth date: ____/____/__________ Sex: ☐ M ☐ F

Address: ____ Home Phone: (_____) ________ - __________

City: ______________________ State: _____ Zip: __________ Cell Phone: (________) _________ - ____________

Email: ____

Employer: ____ or Retired / Part-time Student / Full-time Student

Employer Address: ____________________________________ City/State/Zip: ___________________________

Occupation: ____ Marital Status: ☐ M ☐ S ☐ W ☐ D ☐ U

Who may we Thank for your referral? ____

Emergency Contact: ____

Contact Phone: (________) ________ - ___________

Relation to Patient: _____________________________

Your Agreement

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor/therapist at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for all dental treatment to be rendered by Mike Cantrell, PT, Dr. Alice Lam, James Guzman, PT and office staff.

I authorize the release any information including the diagnosis and the records of any treatment or exam rendered to me or my child during the period of such care to my insurance company and/or health practitioners. I agree to be ultimately responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor

____Date_____________

I authorize Dr. Lam the use of my records including any photographs taken for teaching or educational study clubs/seminars and/or marketing purposes.

Signature____Date_____________

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PATIENT MEDICAL HISTORY

Patient Name ______________________________ Referring Physician: ________________________________

Date of First Doctor Visit for this Injury/Episode: _______ Family Physician: _______________________________

Date Last Worked Due to this Injury/Episode: __________ Occupation: __________________________________

Date Returned to Work after this Injury/Episode: ________ Is an Attorney involved in this case: ☐ Yes ☐ No

Have you had Surgery on this body part? ☐ Yes ☐ No Number of Surgeries on this body part? : 1 2 3

Type of Surgery: _______________________________________ Height: ____________ Weight: __________

Are you currently taking any prescription or non-prescription medications? ☐ Yes ☐ No

☐Anti-inflammatory drugs Drug: ____

☐Muscle relaxers Drug: ____

☐Pain medication Drug: ____

☐Other Drug: ____

Have you had any of the following medical or rehabilitative services for this Injury/Episode?

	YES	NO
Chiropractor		
EMG/NCV		
Massage Therapist		
Myelogram		
Occupational Therapy		
Physical Therapy		
Emergency Room Care		

	YES	NO
CT Scan		
General Practitioner		
MRI		
Neurologist		
Orthopedist		
Podiatrist		
X-rays		

Do you now have, or have you ever had any of the following?

	YES	NO			YES	NO
Asthma, bronchitis, emphysema				Severe or frequent headaches		
Shortness of breath/ chest pain				Vision or hearing difficulties		
Coronary Heart Disease/ Angina				Numbness or tingling		
Do you have a pacemaker?				Dizziness or fainting		
High blood pressure				Ringing in your ears		
Heart attack or heart surgery				Weakness		
Stroke/ TIA				Weight loss/ Energy loss		
Blood clot/ embolism				Hernia		
Epilepsy/ seizures				Tuberculosis		
Thyroid trouble/ Goiter				Allergies		
Anemia				Any pins or metal implants		
Infectious Diseases				Joint replacement		
Diabetes				Neck injury/ surgery		
Cancer/Chemotherapy/Radiation				Shoulder injury/ surgery		
Arthritis/ Swollen joints				Elbow injury/ surgery		
Osteoporosis				Back injury/ surgery		
Gout				Knee injury/ surgery		
Sleeping problems/ difficulties				Leg/ Ankle/ foot injury/ surgery		
Emotional/ Psychological problems				Are you pregnant?		
Bowel or Bladder problems				Do you smoke?		

List any other information that would assist us in your care: ____

Are you aware of your diagnosis? ☐ Yes ☐ No

Based on your awareness, what are your expectations/goals while in this program? _________________________

Patient / Guardian Signature ____ Date _________________

Back Index

Form BI100

rev 3/27/2003

Patient Name ______________________ ***Date*** __________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Disabilities of the Arm, Shoulder and Hand

Name:______________________________ Date:_________________

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

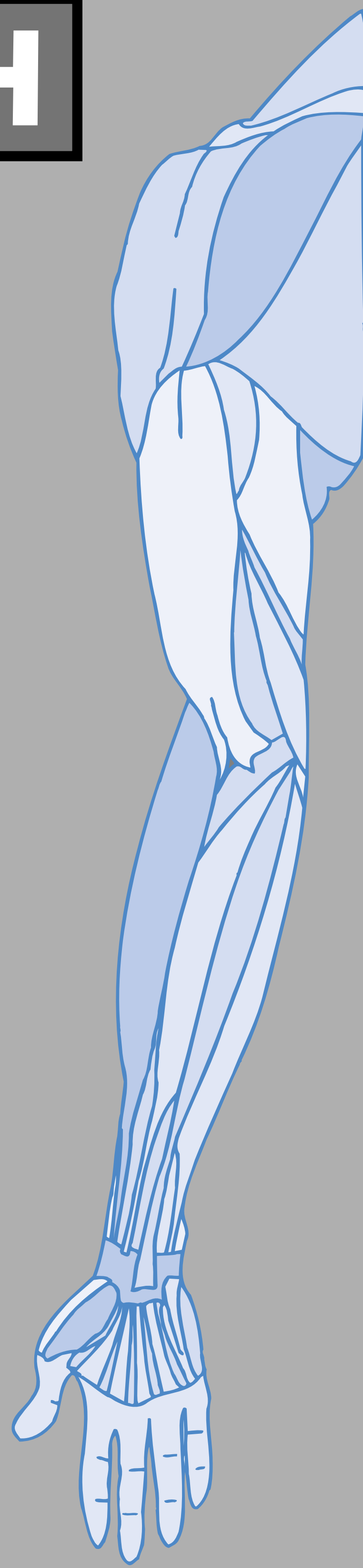
	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may not be calculated if there are greater than 3 missing items.

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:____________________

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*.
If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:____________________

❒ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may not be calculated if there are any missing items.

INSTITUTE FOR WORK & HEALTH
INSTITUT DE RECHERCHE SUR LE TRAVAIL ET LA SANTÉ

Name:______________________________________ 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.

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, re creational 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**

Please submit the sum of responses.