General Consent and Acknowledgement Form

Notice of Privacy Practices

You have received services from one of the University of Delaware's health care providers, collectively, "UD Health". You have a right to know how UD Health protects your personal information. We describe these practices on our Notice of Privacy Practices, which we have provided to you.

(Additional copies of the Notice of Privacy Practices are available at any of the above listed UD Health locations. You may also obtain a copy by sending a written request to the UD Health's Privacy Officer, 112 Hullihen Hall, Newark, DE 19716. Please refer to UD Health's Notice of Privacy Practices for more information about your privacy rights. If you believe your privacy rights have been violated, you may file a complaint with the UD Health's Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with UD Health's Privacy Officer, write to Privacy Officer, University of Delaware, 112 Hullihen Hall, Newark, DE 19716. All complaints must be submitted in writing. UD Health will not penalize you for filing a complaint.)

Please verify that you have received a copy of our Notice of Privacy Practices.

Printed Patient Name: ____

Signature: _________________________________ **Date**: ______________________

If not signed by the person receiving services, please indicate your relationship/authority to sign on this person's behalf.:

____

Consent for Treatment

I consent to services that my provider feels are medically necessary for health care treatment and diagnostic procedures provided by UD Health clinics and its practitioners, clinicians and therapists. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at UD Health. I understand that I can withdraw my consent at any time.

I agree to be contacted via email or SMS with information pertaining to my visit including patient portal invitation, patient surveys, appointment or check up reminders or new services that relate to me or my family. I understand that I can withdraw this consent at any time.

I authorize payment of medical benefits to UD Health practitioners, clinicians and therapists for services rendered.

Financial Policy

I have received and understand UD Health's financial disclosure form and I agree to its terms. I also understand and agree that such terms may be amended by the practice occasionally. We will issue a revised Financial Disclosure Form which will contain the changes.

Consent for Alternate person to bring Minor Child/Dependent/Care Giver to Appointment

I understand that as the Parent/Guardian, I must bring my child to the first appointment with a UD Health provider, in order to give a complete medical history. Following the first appointment, I give permission for the following individual(s) to bring my child to UD Health for treatment. I understand that by giving permission for this individual(s) to bring my child to their appointment, the individual(s) is fully permitted to consent to treatment recommended by UD Health.

Alternate individual that may bring child/dependent/care partner to UD Health for Treatment

Name	**Relationship**
____	____________________________________
____	____________________________________

Consent for minor to receive medical care without an accompanying adult. This consent only applies to minors age 16 or older and shall be in effect for: ___________Date(s): _________________

___Indefinitely, until revoked in writing

Consent to Release Information

In order for any family members/care givers to receive any medical information, you must provide consent.

If you wish to have any individuals be able to receive medical information, diagnostic test results and/or financial information, please list below. These individuals may NOT consent to any procedure for you as the patient. You may revoke your consent at any time, except where we have already made disclosures based on your prior consent.

Yes: Initials______________ No____________

If yes, please list:

Name:______________________________________ Relationship:________________________________

Cancellations, Late Patients and No Show

UD Health aims to offer excellent patient care and services. In order to make the most of the time a provider can be with you and reduce your wait time, we have a standard policy for cancellations, late patients and no shows. By initialing below, you acknowledge our practices and agree to follow our policies.

Cancellations: We require 24 hours notice for any cancellations.

Late: You will be considered late if you arrive 10 minutes or more after your scheduled appointment time. There may be times where your appointment will need to be rescheduled, if you go over this time frame.

No Show: If you do not arrive or let us know about not being able to attend your scheduled appointment time, you may risk your ability to schedule with UD Health.

Research:

UD Health strives to improve patient care and results by participating in multiple research studies. Our improvement in patient care depends on patients that qualify to participate in studies. If you are a good candidate for a study and would be willing to be contacted by our Research team to be screened for the study, please initial. Agreeing to be contacted **DOES NOT** mean that you will be enrolled in research. _________**Initial**

Photographing and Videotaping:

UD Health, LLC may photograph, film, videotape, audiotape or store all or a portion of my treatment. Recordings may include images and/or voices of anyone who participates in my evaluation or treatment during my appointment. I understand that UD Health, LLC may use these photographs, film, videotape or audiotape for evaluation and treatment as well as for the educational purposes of University of Delaware students, quality assessment and clinical activities or for any other health care operations at UD Health, LLC. This consent includes storing of the recordings for possible future research studies that I may be eligible to participate.

Forms

A charge may apply for forms such as physical, disability and FMLA, to be completed outside of normal appointment times. The charge for completion is $20.00 per form. Please let us know if you need forms to be completed, so we can schedule correctly. There is no charge for forms completed during your normal appointment time.

I certify that I have read, understand and agree to all terms and conditions outlined above. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Signature: ____Date: ________________
Time:______________

PHYSICAL THERAPY CLINIC

HEALTH HISTORY

Patient Name: ________________________________

Today's Date: ________________ Have you ever had these symptoms before (circle): Yes / No

Date of Injury/onset: ____________ If so, when: ____________

The following is a list of common health problems. In the first column please indicate if you currently or have ever had any of the problems in the past. In the second column please indicate if you are currently receiving treatment for the problem. In the last, please indicate if the problem currently limits any of your daily activities.

	Do you or have you had the problem?		Do you currently receive treatment for this problem?		Does this problem limit your daily activities?	
	Y	N	Y	N	Y	N
Abnormal Blood Pressure	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Anemia or blood condition	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Autoimmune Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Cardiac Conditions	☐	☐	☐	☐	☐	☐
Cardiac Pacemaker	☐	☐	☐	☐	☐	☐
Chemical Dependency	☐	☐	☐	☐	☐	☐
Circulation Problems	☐	☐	☐	☐	☐	☐
Currently Pregnant	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Dizzy Spells	☐	☐	☐	☐	☐	☐
Emphysema/Bronchitis	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐
Fractures	☐	☐	☐	☐	☐	☐
Gall Bladder problems	☐	☐	☐	☐	☐	☐

HEALTH HISTORY

	Do you or have you had the problem?		Do you currently receive treatment for this problem?		Does this problem limit your daily activities?	
	Y	N	Y	N	Y	N
Headaches	☐	☐	☐	☐	☐	☐
Hearing Impairment	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐	☐
Incontinence	☐	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐	☐
Metal Implants	☐	☐	☐	☐	☐	☐
MRSA	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐
Muscular Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Smoking	☐	☐	☐	☐	☐	☐
Speech/Communication	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Vision problems	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐
Ulcer or Stomach Disease	☐	☐	☐	☐	☐	☐
Nausea/Vomiting	☐	☐	☐	☐	☐	☐
Hernia	☐	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐	☐
Ringing in the ears	☐	☐	☐	☐	☐	☐
Sexual Dysfunction	☐	☐	☐	☐	☐	☐
Fainting	☐	☐	☐	☐	☐	☐
Nerve Disease/Disorder	☐	☐	☐	☐	☐	☐

HEALTH HISTORY

	Do you or have you had the problem?		Do you currently receive treatment for this problem?		Does this problem limit your daily activities?	
	Y	N	Y	N	Y	N
Skin Disorder	☐	☐	☐	☐	☐	☐
Menstrual irregularities	☐	☐	☐	☐	☐	☐
Recent unexplained weight loss or gain	☐	☐	☐	☐	☐	☐
Numbness or tingling	☐	☐	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐	☐	☐

Have you ever tested positive for COVID-19? ☐yes ☐no If YES, when were you cleared by the Dept. of Health? Month__________ Day________ Year__________

Have you been injured as a result of a fall in the past year? ☐yes ☐no

Have you had more than 2 falls within the past year? ☐yes ☐no

During the past month, have you often been bothered by feeling down, depressed, or hopeless?

☐ Not at all	☐ Several Days	☐ More than half the days	☐ Nearly every Day
0	1	2	3

During the past month, have you often been bothered by little interest or pleasure in doing things?

☐ Not at all	☐ Several Days	☐ More than half the days	☐ Nearly every Day
0	1	2	3

* If subtotal 3 or greater – move onto BDI and contact referring physician

<u>Surgeries with corresponding months and years (please list body region and then surgery and date i.e. right shoulder – rotator cuff repair July 2009):</u>

____

____

____

<u>Current Medications, dosage, and reasons for taking:</u>

____

____

____

____

Signature: ______________________________ Date: ________________

Relationship to patient: ______________________________

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Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
PFA11	Are you able to do chores such as vacuuming or yard work?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA21	Are you able to go up and down stairs at a normal pace?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA23	Are you able to go for a walk of at least 15 minutes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA53	Are you able to run errands and shop?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDANX01	I felt fearful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX40	I found it hard to focus on anything other than my anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX41	My worries overwhelmed me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX53	I felt uneasy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Depression **In the past 7 days...**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDDEP04	I felt worthless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP06	I felt helpless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP29	I felt depressed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP41	I felt hopeless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
HI7	I feel fatigued	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
AN3	I have trouble starting things because I am tired	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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	Fatigue **In the past 7 days…**	Not at all	A little bit	Somewhat	Quite a bit	Very much
FATEXP41	How run-down did you feel on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
FATEXP40	How fatigued were you on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Sleep Disturbance **In the past 7 days…**	Very poor	Poor	Fair	Good	Very good
Sleep109	My sleep quality was	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
Sleep116	My sleep was refreshing.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Sleep20	I had a problem with my sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep44	I had difficulty falling asleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Ability to Participate in Social Roles and Activities	Never	Rarely	Sometimes	Usually	Always
SRPPER11_CaPS	I have trouble doing all of my regular leisure activities with others	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
SRPPER18_CaPS	I have trouble doing all of the family activities that I want to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
SRPPER23_CaPS	I have trouble doing all of my usual work (include work at home)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
SRPPER46_CaPS	I have trouble doing all of the activities with friends that I want to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	Pain Interference **In the past 7 days…**	Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ9	How much did pain interfere with your day to day activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ22	How much did pain interfere with work around the home?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ31	How much did pain interfere with your ability to participate in social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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	Pain Interference **In the past 7 days…**	Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ34	How much did pain interfere with your household chores?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Pain Intensity **In the past 7 days…**											
Global07	How would you rate your pain on average?	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst pain imaginable**

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Patient Name: ______________________________ **Date:** ______________

Patient-Specific Functional Scale (PSFS)

Please list at least 3 different activities that you are having difficulty with as a result of your injury/need for physical therapy. Today are there any activities you are unable to do or having difficulty with as a result of your injury/need for physical therapy?

As you list these activities, please rate the difficulty associated with these activities based on the following scale:

Patient-specific activity scoring scheme (Please choose one number per activity):
Rate each activity on a scale of 0-10; 0 being unable to perform the activity and 10 being able to perform the activity at the same level as before injury or problem.

0 1 2 3 4 5 6 7 8 9 10

Activity 1: ______________________________

____

____

Today's rating: ______

Activity 2: ______________________________

____

____

Today's rating: ______

Activity 3: ______________________________

____

____

Today's rating: ______

Adapted from: Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individualpatients: a report of a patient specific measure. Physiotherapy Canada, 47, 258263.