

5241 R Street
Lincoln, NE 68504
primengagement.com



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Primengagement@gmail.com

Thank you for allowing us to learn more about you in order to best determine if and how we may be of help to you. Because we are looking at you as a whole person we would like some more information from you. This packet contains information about the information we would like to get from you as well as people who have worked with you in the past. This information will be used for us to make a determination if you are a candidate for our program and will be our intake paperwork that will be shared with our PRIME team should you come to Lincoln. No additional intake paperwork should be necessary. If you have additional questions or concerns please do not hesitate to contact us.

Sincerely,

The PRIME team

What we need to determine if you are a candidate for our program prior to scheduling:

- PRIME Referral Form, filled out by the referral source (if applicable)**
- PRIME Program Questionnaire, filled out by the patient or parent**
- Dental and Foot Pictures (see next page for examples)**
- Copy of the last 3 eye exams. The most recent one must be within the past 18 months if you wear no prescription or if you wear glasses, within 8 months if you wear contact lenses. The exam record is NOT the same as a glasses or contact Rx, so please send ask the office to send the entire exam record.**

Please send all information to the PRIME team:

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Dental and Foot Pictures of you we need: Feel free to attach or e-mail separately

Left



Right



Front



*Stand with Feet Hip Width Apart,
in Comfortable, Natural Position,
Knees Showing*



Close Up in Same Position as 1st one



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PRIME (Postural Restoration® Integrative Multidisciplinary Engagement™) Questionnaire:

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Lori Thomsen, MPT, PRC
Ron Hruska, MPA, PT
Chris Campbell, DDS

David Drummer, DPT, PRC
Jason Masek, MSPT, ATC, CSCS, PRC
Paul Coffin, DPM
Rebecca Hohl, DDS, MS

Date _____

Patient Name (F) _____ (MI) _____ (L) _____ Preferred Name _____

Address _____ City _____ State/Zip _____

Social Security Number _____ Date of Birth _____ Male Female

Email Address _____ Home Phone () _____ Cell () _____

Employer _____ Occupation _____

Work Phone () _____ Ext. _____

Spouse's Name _____ Spouse's Employer _____

Person Responsible for Account _____ Address _____

Emergency Contact and Phone number _____

Referring Provider _____ City/State _____

Primary Eye Doctor _____ City/State _____ Phone _____

Primary Physician _____ City/State _____ Phone _____

Primary Denist _____ City/State _____ Phone _____

Insurance Provider _____ Dental Insurance Coverage (Y/N) Company _____

Insured's Name and Employer _____

Insured's Date of Birth _____ Insured's Social Security Number _____

"Engager" That Will Attend PRIME With You: _____ Relationship: _____

Patient Name (F) _____ (MI) _____ (L) _____ DOB _____

Chief complaints and reasoning behind your need to participate in the **PRIME** Program. Examples: Headaches, dizziness, vertigo, back pain, etc.

This began: _____

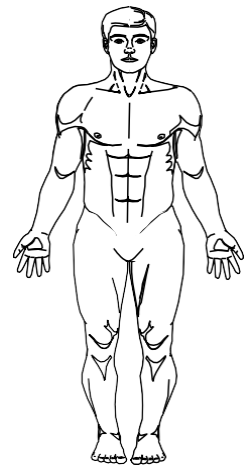
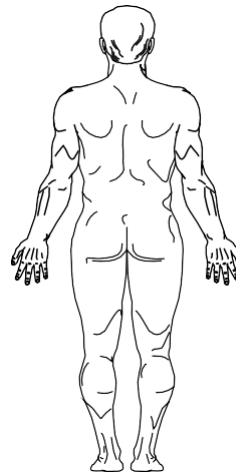
What is it you want to do that you can't do now? _____

I am happiest when I participate in these activities:

PLEASE INDICATE ON THE PICTURES THE **LOCATION OF YOUR ISSUE(S)** &
PLEASE INDICATE YOUR LEVEL OF DISCOMFORT AT ITS **WORST AND BEST** ON THE SCALE BELOW

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

0 = NO DISCOMFORT 10 = EXTREME DISCOMFORT



Is the pain associated with a certain situation?

- | | | |
|-----------------------|-----|----|
| Standing | YES | NO |
| Walking | YES | NO |
| Sports | YES | NO |
| Running | YES | NO |
| Getting up in morning | YES | NO |
| Specific Shoes | YES | NO |
| Keeps awake at night | YES | NO |

Other? _____

Does anything make the symptoms better? _____

GENERAL HEALTH:

- | | | |
|--------------------|-----|----|
| Diabetes? | YES | NO |
| Weight Loss? | YES | NO |
| Digestive Disease? | YES | NO |
| Metal Implants? | YES | NO |
| Heart Problem? | YES | NO |
| Depression? | YES | NO |
| Anxiety? | YES | NO |
| Seizures? | YES | NO |

Please list all medications you are currently taking and for what condition:

Other? _____

Previous Surgery(s) or Significant Trauma: _____

****If you've had changes in your medical history such as medications, hospitalizations, or illnesses, please notify us.***

Patient Name (F) _____ (MI) _____ (L) _____ DOB _____

PRIME Physical Therapy Information

Do you have, or have you had, any of the following:

NECK/JAW/HEAD:

Tension in your neck or at the base of your skull	YES	NO
Torticollis	YES	NO
Headaches	YES	NO
Migraines	YES	NO
Head Trauma	YES	NO
Whiplash	YES	NO
Concussion	YES	NO
Loss of consciousness	YES	NO

Were any of these traumas followed by symptoms right after the event? If yes, please explain:

Tone or ringing in ear(s)	YES	NO
Ear pressure	YES	NO
Wake up with a dry mouth	YES	NO
Without rotating or moving your body, can you turn your head to each direction?	YES	NO
Do you feel limitations to either direction?	YES	NO
If yes, which direction? _____		
Can you move your jaw to either side without limitation or pain?	YES	NO
If no, please explain: _____		
Are you missing any molars (other than wisdom teeth)?	YES	NO
Are you in active orthodontia?	YES	NO
If yes, Invisalign or Brackets? _____		
Do you presently have any oral appliance?	YES	NO
If yes, is it for the top or bottom? _____ When do you use it? _____		
Do you have any dental/orthodontic treatment planned in the next 12 months?	YES	NO
If yes, what type of treatment? _____ When is treatment planned? _____		

LUMBO/PELVIC/FEMORAL:

Small amounts of urine leakage when you cough, sneeze, laugh, lift or exercise	YES	NO
Pain, discomfort or pressure in your pelvic area when sitting or standing	YES	NO
Hip or groin pain	YES	NO
Low back pain	YES	NO
Scoliosis	YES	NO
Frequent trips to the bathroom	YES	NO
Lateral leg or ankle strain	YES	NO
Sense one leg feeling longer or shorter than the other	YES	NO
Have a favorite pair of shoes	YES	NO
If yes, what is it about them you like? _____		

Prefer NOT to wear shoes YES NO

Have you had anything happen that affected your ability to walk? (eg, being in a walking boot, on crutches, etc) _____

BREATHING:

Feel tired after a full night of sleep	YES	NO
Asthma	YES	NO
Have to sleep in an upright position	YES	NO
Diagnosed with sleep apnea	YES	NO
Snore	YES	NO
Use an inhaler	YES	NO
Difficulty breathing with simple activity, i.e.: going up steps	YES	NO

Hand Dominance (please circle one): Right-handed Left-handed

Is there anything else significant about your physical or health history we need to be aware of?

Patient Name (F) _____ (MI) _____ (L) _____ DOB _____

PRIME Vision Information

Do you have, or have you had, any of the following:

Lazy Eye	YES	NO
Eye Turn	YES	NO
Double vision	YES	NO
Intermittent blurred vision	YES	NO
Lose place while reading	YES	NO
Difficulty with reading comprehension	YES	NO
Difficulty with concentration or mental fog	YES	NO
Eyestrain	YES	NO
Pain behind eye(s)	YES	NO
Light sensitive	YES	NO
Hypersensitivity to sound	YES	NO
Hypersensitivity to movement	YES	NO
Occasionally bump into objects while walking	YES	NO
Balance Issues	YES	NO
Dizziness	YES	NO
Frequent or large changes in vision prescription	YES	NO
Difficulty driving at night	YES	NO
Retinal Detachment	YES	NO
Macular Degeneration	YES	NO
Glaucoma	YES	NO
Cataracts	YES	NO
Eye Surgery	YES	NO

When was your last eye examination? _____

Do you wear glasses now?	YES	NO	When? _____
Do they have a bifocal in them?	YES	NO	Is it lined or no-line? _____
What age did you first need glasses? _____			

Do you have difficulty at the computer?	YES	NO
Do you have a separate pair of glasses for this?	YES	NO
Number of hours/day on a computer: for work _____		For pleasure _____

Do you wear contact lenses at this time?	YES	NO	When? _____
Are they bifocal style?	YES	NO	
Is one contact for distance and one for near in the other eye?			
	YES	NO	How long have you used these? _____
Do you wear sunglasses?	YES	NO	
Are they prescription?	YES	NO	

Please summarize any vision treatments, other than glasses or contacts, you have had or are currently undergoing, such as patching, vision therapy, using special tints or lenses, dry eye therapy, etc. _____

Patient Name (F) _____ (MI) _____ (L) _____ DOB _____

PRIME Podiatry Information

Shoe size? _____ Narrow Medium Wide (please circle one)

Does your job require standing/walking for long periods of time? YES NO

What kind of shoes do you wear for everyday? _____ Sports? (brand if known) _____

Do you participate in (circle all that apply):

- | | | | |
|------------|-------------|---------------|----------|
| Walking | Tennis | Cross Country | Football |
| Running | Golf | Marathons | Track |
| Baseball | Volleyball | Triathlons | Biking |
| Basketball | Gymnastics | Hockey | Soccer |
| Dance | Other _____ | | |

On what level?

- | | |
|-----------------|--------------|
| Occasional | School Team |
| For Exercise | College |
| For Competition | Professional |

Are you currently training for a special competition? NO YES _____

What % of the time do you wear the following footwear?

- | | | |
|-------------------|--------------------|---------------------|
| Athletic _____% | Dress Shoes _____% | Casual Dress _____% |
| High Heels _____% | Sandals _____% | Flip Flops _____% |
| Work Boots _____% | Barefoot _____% | Other _____% |

Do you wear Orthotics? NO YES From where? _____ What kind? _____

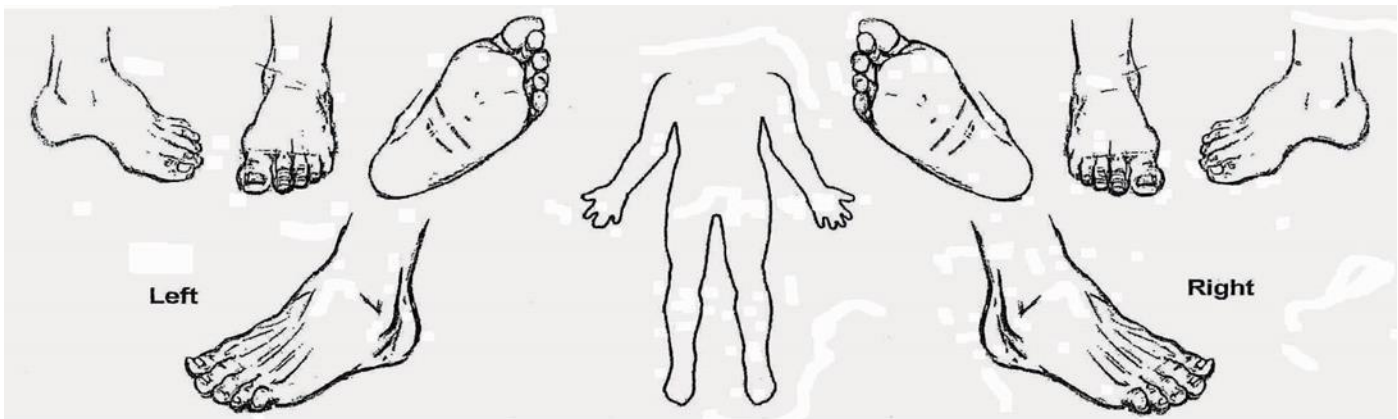
Heel Lift? _____ Other foot Inserts? _____

Circle any pain you are having:

- Burning Throbbing Aching Gnawing Stabbing Shooting Numbness

How severe is the pain? Mild 1 2 3 4 5 6 7 8 9 10 Severe

Mark the location of your problem:



Circle any that apply:

- | | | | |
|-------------|--------------------|-----------------------------------|---|
| Bunions | Hammertoes | Frequent ankle sprains | Problems with feet/special shoes in childhood |
| Callouses | Achilles pain | Feet roll in/out | Feel unstable on one or both feet |
| Back pain | Wide feet | Swelling in feet, lower legs | |
| Narrow feet | High arches | Knee or hip pain | |
| Flat feet | Frequent cold feet | Knee or hip replacement | |
| Frostbite | Burning feet | Difficulty finding shoes that fit | |
| Intoe | Outtoe | Family history of foot problems | |

Patient Name (F) _____ (MI) _____ (L) _____ DOB _____

PRIME Dental Information

Frequency of dental check ups: once/year _____ twice/year _____

Date of last dental exam _____

List any drug allergies or sensitivities you may have _____

Answer yes or no if applicable now or in the past:

- | | |
|--|--|
| Y N Allergies (latex-gloves/balloons) | Y N Allergies (metals-jewelry/clothing) |
| Y N Allergies (acrylic) | Y N Allergies (medication) |
| Y N Allergies (food) | Y N Allergies (seasonal) |
| Y N Are you pregnant (females) | Y N Frequent headaches/migraines |
| Y N Have OR have you had braces | Y N Presently wearing a mouthpiece |
| Y N Jaw or facial pain | Y N Clicking, popping or jaw opening limitations |
| Y N Any teeth pulled | Y N Implants, bridges or partials |
| Y N Difficulty chewing or opening jaw | Y N Apprehensive about dental care |
| Y N Cysts or mouth infections | Y N Brush teeth daily |
| Y N Frequent clenching of teeth | Y N Floss teeth daily |
| Y N Injury to either jaw | Y N Fluoride treatments |
| Y N Injury involving teeth | Y N Previous orthodontic therapy |
| Y N Thumb/finger sucking habit | Y N Frequent canker sores |
| Y N Frequently chews gum | Y N Had periodontal treatment |
| Y N Speech therapy | Y N Wake up with sore teeth |
| Y N Wake up with sore jaw | Y N Discomfort from teeth or gums |
| Y N Any missing permanent teeth | Y N Body piercing |
| Y N Bleeding gums | Y N Sleeps with mouth open |
| Y N Teeth that are shifting | Y N Gag reflux |
| Y N Any injuries to face, mouth, teeth | Y N Mouth breathing |
| Y N Anemia | Y N Oral Surgery |
| Y N Emotional problems | Y N Hormone therapy |
| Y N HIV/AIDS | Y N Arthritis |
| Y N Hepatitis | Y N Radiation treatment |
| Y N Rheumatic fever | Y N Handicap/disabilities |
| Y N Family history of cancer | Y N Requires premedication |
| Y N Ever been hospitalized | Y N Tuberculosis |
| Y N Heart disease | Y N Bone disorder/bone loss |
| Y N Enlarged tonsils | Y N Tobacco use |
| Y N Liver disease | Y N Immunodeficiency |
| Y N Tonsils/Adenoids removed | Y N Bottle-fed |
| Y N Kidney disease | Y N Endocrine problems |
| Y N Frequent sore throats | Y N Breastfed |
| Y N Lung disease | Y N Heart murmur |
| Y N Cleft palate/lip | Y N Born premature (___ weeks) |
| Y N Pneumonia | Y N Heart attack/stroke |
| Y N Congenital heart defect | Y N Hemophilia |
| Y N Tongue thrust | Y N Frequent nausea |
| Y N Growth problems | Y N Psychological counseling |
| Y N Autism | Y N ADHD |

Other _____

If you answered yes to any of the above, please explain (if not previously explained in your information):

Patient Name (F) _____ (MI) _____ (L) _____ DOB _____

MEDICALLY INFORMED CONSENT AND ASSIGNMENT AND RELEASE

I voluntarily consent to treatment (vision, dentistry, podiatry, physical therapy) and services deemed necessary by my Postural Restoration Integrative Multidisciplinary Engagement™ (PRIME) Clinical Integrative Specialist. I also consent to have my medical information included in the PRIME Questionnaire shared with the multiple disciplines within the PRIME team. Information will not be utilized outside of our PRIME team unless specific consent is obtained from you, the patient. As a patient, I am aware that these practices are not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services within the PRIME program. It is our PRIME team's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques that are being used to retrain, recruit & restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's/optometrist's/podiatrist's/dentist's objectives and outcomes are, and how he/she is trying to achieve them. This consent shall be ongoing for a period not to exceed one year.

I hereby understand that I am financially responsible for these non-covered services. All of the information provided is correct and true to the best of my knowledge. **I am responsible for all charges incurred during my participation in the PRIME program.**

I (or _____ for _____) have read this form and fully understand and accept its terms and conditions.

Patient or person authorized to consent for patient / relationship Date / Time

Reason patient was unable to consent Witness signature

Acknowledgement of Receipt of Notice, **PRIVACY PRACTICES** PRIME Program

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Patient Name (F) _____ (MI) _____ (L) _____ DOB _____

Our office's complete NOTICE OF PRIVACY PRACTICES

Our complete Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To other health care practitioners involved in our PRIME program;
- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations & other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas & as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notices of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to our complete Notice of Privacy Practices for the person or persons whom you may contact.