5241 R Street
Lincoln, NE 68504
primengagement.com

Phone: (402)975-8533
Fax: (402)467-4580
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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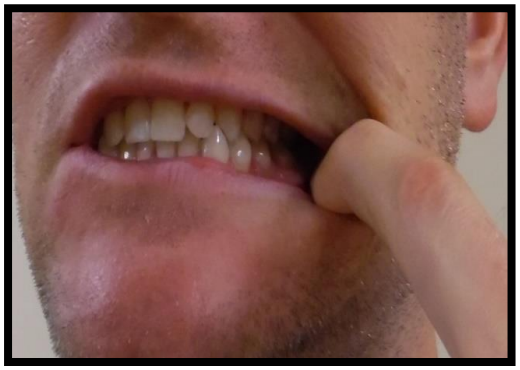
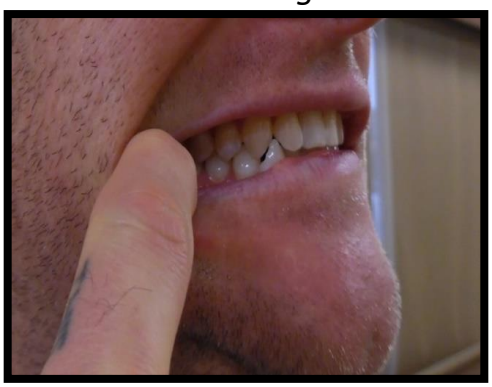
Dental and Foot Pictures of you we need: Feel free to attach or e-mail separately

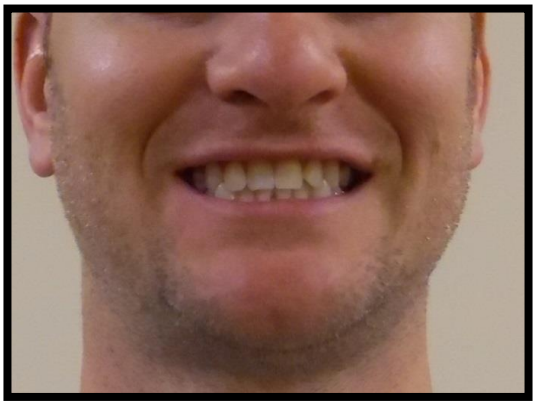
Left



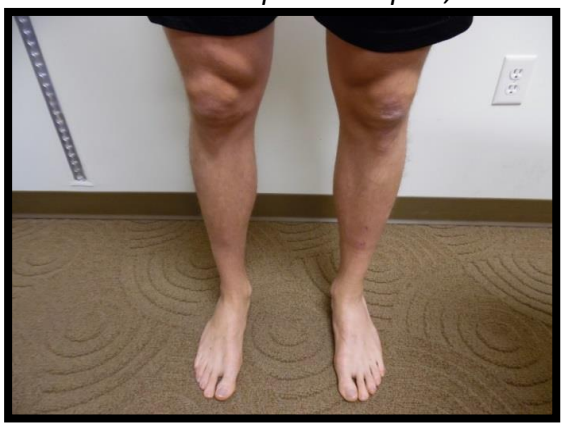
Right

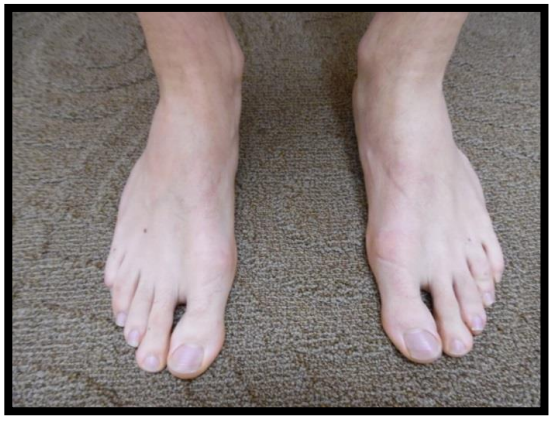


Front



Stand with Feet Hip Width Apart, in





<u>If you are currently wearing an oral appliance please include a picture of it in and out of your mouth with these other application photos**</u>**

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

Torin Berge, MPT, PRC **David Drummer, DPT, PRC**
Lori Thomsen, MPT, PRC **Jason Masek, MSPT, ATC, CSCS, PRC**
Ron Hruska, MPA, PT **Paul Coffin, DPM**
Chris Campbell, DDS **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 Occupation _____

Person Responsible for Account_____Address_____

Emergency Contact and Phone number_____

Referring Provider_____City/State_____PRI Trained? Y/N_____

Primary Eye Doctor_____City/State_____Phone_____

Primary Physician_____City/State_____Phone_____

Primary Dentist_____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:_____

_____

What have you done to address your symptoms so far (PT, surgery, Chiropractic etc.)? Include PRI and non-PRI practitioners._____

_____

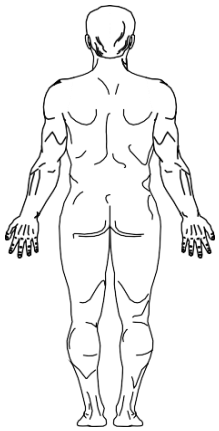
_____

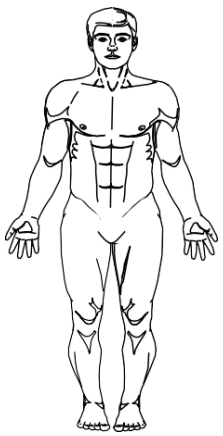
_____

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

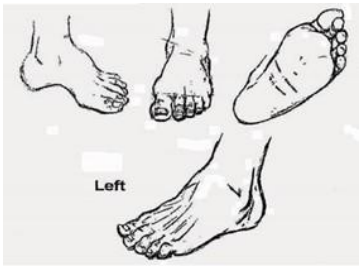
Other? _____

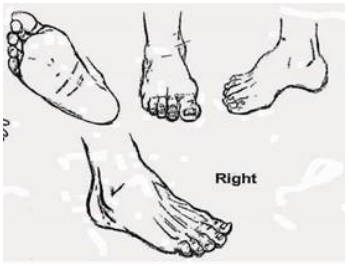
_____

Does anything make the symptoms better? _____

_____

_____





Circle any that apply:

Bunions	Hammertoes	Frequent ankle sprains	Problems with feet/special shoes in childhood
Callouses	Achilles pain	Feet roll in/out	
Back pain	Wide feet	Swelling in feet, lower legs	Feel unstable on one or both feet
Narrow feet	High arches	Knee or hip pain	
Flat feet	Frequent cold feet	Knee or hip replacement	
In-toe	Out-toe	Difficulty finding shoes that fit	

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

GENERAL HEALTH:

Diabetes?	YES	NO
Weight Loss?	YES	NO
Digestive Disease?	YES	NO
Metal Implants?	YES	NO
Depression?	YES	NO
Anxiety?	YES	NO
Seizures?	YES	NO
Heart problems?	YES	NO
Allergies?	YES	NO

OTHER GENERAL HEALTH ISSUES NOT DESCRIBED:

_____

_____

_____

_____

PREVIOUS SURGERIES OR SIGNIFICANT TRAUMAS:

_____

_____

_____

_____

Please List any allergies: _____

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

_____

_____

_____

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

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

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? _____		
Do you clench or grind your teeth?	YES	NO
Does your jaw pop or click with opening?	YES	NO
Can you move your jaw to either side without limitation or pain?	YES	NO

If no, please explain:_____

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

Have you had any jaw or tooth injuries? YES NO
Are you missing any permanent teeth (other than wisdom teeth)? YES NO
If yes, which ones?_____

Have you had orthodontia? YES NO

Are you in active orthodontia? YES NO
If yes, Invisalign or Brackets? [Circle one]
Do you presently have any oral appliance? YES NO
If yes, is it for the top or bottom?_____When do you use it? _____

****If you are currently wearing an appliance please include a picture of it in and out of your mouth with your other application photos****

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? _____
Do you have implants, bridges or partials? YES NO
Do you have a history of speech therapy needs? YES NO
Have you been told you have a tongue thrust or issues with your tongue? YES NO

BREATHING:

Feel tired after a full night of sleep	YES	NO
Sleep with mouth open/wake up with dry mouth or snore	YES	NO
Enlarged Tonsils	YES	NO
Asthma	YES	NO
Use inhaler	YES	NO
Diagnosed with sleep apnea	YES	NO
Use CPAP/BiPAP	YES	NO
History of sinus surgeries	YES	NO
Difficulty breathing with simple activity, i.e. going up flight of stairs	YES	NO

LUMBO/PELVIC/FEMORAL:

Small amounts of urine leakage when you cough, sneeze, laugh, lift, etc.	YES	NO
Pain, discomfort or pressure in your pelvic area when sitting or standing	YES	NO
Hip or groin pain	YES	NO
Chronic 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 feels shorter or longer than the other	YES	NO

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 is your favorite shoe to wear for everyday?_____For Sports? (brand)_____

What is it about them that you like?_____

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

Have you been recommended to wear certain shoes? YES NO Which ones?_____

Do you have a history of ankle sprains or traumas to your feet or ankles? YES NO

Explain:_____

Any injuries to your legs that ever affected your ability to walk (i.e needed crutches or walking boot)? YES NO

Explain:_____

What types of activities do you participate in (i.e running, tennis, soccer, dance etc.) _____

_____

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

Who prescribed them?_____What kind?_____

Heel Lift?_____Other foot Inserts?_____

PRIME Vision Information

Do you have or have you had any of the following?

Lazy eye/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 eyes	YES	NO
Light Sensitive	YES	NO
Hypersensitive to sound	YES	NO
Hypersensitive to movement/motion sickness	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?_____

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

Do you wear glasses now? YES NO

For what do you wear them: [Circle all that apply]

Distance Reading Computer Driving

Do they have a bifocal? YES NO

Lined or No-lined [circle one]

At what age did you first need glasses:_____

Do you have difficulty at the computer? YES NO

Number of hours a day on screens: For Work:_____

For Pleasure:_____

Are you, or have you been in, monovision correction? YES NO

If YES for how long have you been in monovision correction?_____

Do you wear contact lenses at this time? YES NO

When?_____

Are they bifocal contacts?_____

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.

_____

_____

_____

Please summarize any other aspects of your medical history, that you feel may be of help to us in relation to your current issues._____

_____

_____

_____

_____

_____

_____

Thank you for your time and energy in filling this out. If you have any questions do not hesitate to contact us. We look forward to getting to know more about you so we can help in whatever manner we can.

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.