



Thank you for considering our program. To best determine if and how we may be of help to you we would like to collect some more information from you. This application asks medical questions from various viewpoints as we are looking at how multiple systems may be related to your issues. Answer the questions to the best of your ability. If you have other history or information from other practitioners (especially with PRI backgrounds) that would be helpful for us but is not necessary. We also want to have you take some pictures of the way your teeth fit from the front and each side and the way your feet and lower legs look as you are standing bare foot. See the next page for examples. Lastly, we need to have a recent (within the last 12 months) eye exam/record from an Optometrist or Ophthalmologist with refraction. We would prefer to have your last three exams to track the progression of your eyes. This information gives us a starting point for your visual system and ensures that someone has checked to see if your eyes are healthy prior to us seeing you here for a vision appointment. Once we have all of this information, it will be reviewed by our team, and we will be able to make a determination if you are a candidate for our program. If you have additional questions about this process please do not hesitate to contact us.

Sincerely,

The PRIME team

What we need from you as part of your application:

- ☐ PRIME Program Questionnaire, filled out by the patient or parent **
- ☐ Dental and Foot Pictures (see next page for examples) **
- ☐ Eye exams: prefer last 3 exams. Most recent must be within the last 12 months.
The exam record is NOT the same as a glasses or contact prescription, so please ask the office to send the entire exam record. **
- ☐ PRIME Referral Form: Recommended if you were referred by another PRI practitioner (optional)

****we will not be able to determine your status until we have all required information****

Please send all information to the PRIME team:

Fax: **402-467-4580** Email: **Primengagement@gmail.com**

5241 R Street
Lincoln, NE 68504
primengagement.com



Phone: (402)467-4545
Fax: (402)467-4580
Primengagement@gmail.com

Dental and Foot Pictures: Feel free to attach or e-mail separately.

1. Close your mouth in your natural bite with your teeth touching how they normally touch.
 2. Take a picture from the front, right and left so we can see how your teeth fit.
- Ideally, we'd like to be able to see your back teeth on either side.

****If you already have a dental appliance (not just retainers) take the same pictures with the appliance in as well.**

Left



Front



Right



3. Stand barefoot with Feet Hip Width Apart, in Comfortable, Natural Position and take the following 2 pictures.

Knees Showing



Close Up of feet in Same Position



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

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Ann Simsar, PT, DPT
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David Drummer, DPT, PRC
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Steve Wise, OD

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. _____

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_____

Person Responsible for Account_____ Address_____

Medical Insurance Provider_____

Insured's Name and Employer_____

Ideally we recommend you bring someone with you to Lincoln to help learn and process the information you will get.

If known, who Will Attend PRIME With You:_____ Relationship:_____

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

I. GENERAL HISTORY:

This information helps us get a general idea of why you may need to come to PRIME.

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? _____

What is your experience with PRI? ☐ I've done A LOT ☐ Some PRI activities ☐ Online only ☐ What is PRI?

If you want to tell, what PRI providers have you worked with? _____

Is the pain associated with a certain situation?

	YES	NO
Standing	☐	☐
Walking	☐	☐
Sports	☐	☐
Running	☐	☐
First thing in morning	☐	☐
Specific Shoes	☐	☐
Keeps awake at night	☐	☐

PLEASE INDICATE ON THE PICTURES THE **LOCATION OF YOUR ISSUE(S)** &

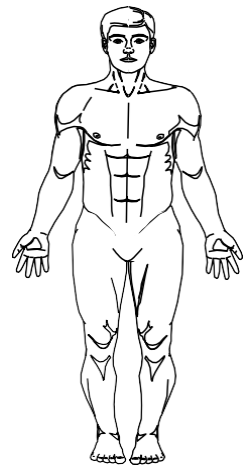
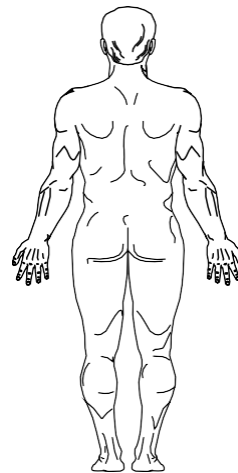
PLEASE INDICATE YOUR LEVEL OF DISCOMFORT AT ITS **WORST AND BEST** ON THE SCALE BELOW

0 1 2 3 4 5 6 7 8 9 10
0 = NO DISCOMFORT 10 = EXTREME DISCOMFORT

What helps alleviate symptoms: _____

GENERAL HEALTH:

	YES	NO
Diabetes?	☐	☐
Unexplained weight loss?	☐	☐
Digestive issues?	☐	☐
Allergies/sensitivities?	☐	☐
Heart Problems?	☐	☐
Depression/Anxiety?	☐	☐
Hearing Loss?	☐	☐
Seizures?	☐	☐
PTSD?	☐	☐
Surgery?	☐	☐
Other? (Explain below)		



Hand Dominance ☐ Right ☐ Left ☐ Ambidexterous

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

List any surgeries you have had: _____

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

II. PRIME Physical Therapy Information:

This information helps our PT team learn more about you from a musculoskeletal lens.

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

<u>NECK/JAW/HEAD:</u>	YES	NO	<u>BREATHING:</u>	YES	NO
Neck or base of skull tension	☐	☐	Asthma	☐	☐
Headaches	☐	☐	Tired after a full		
Migraines	☐	☐	night of sleep	☐	☐
Concussion/head trauma	☐	☐	Sleep in upright position	☐	☐
Whiplash	☐	☐	Diagnosed sleep apnea	☐	☐
Loss of consciousness	☐	☐	If yes... use CPAP/BiPAP	☐	☐
Ringing in ears (Tinnitus)	☐	☐	Snore	☐	☐
Use hearing aids (or should)	☐	☐	Difficulty breathing after		
Ear Pressure/pain	☐	☐	simple activity (i.e. stairs)	☐	☐
Voice/swallowing issues	☐	☐			

Without rotating or moving your body, can you turn your head fully to both directions? ☐ YES ☐ NO

If limited or painful, to which direction? ☐ LEFT ☐ RIGHT ☐ BOTH

Can you move your jaw equally to either side without limitation or pain? ☐ YES ☐ NO

If limited or painful, to which direction? ☐ LEFT ☐ RIGHT ☐ BOTH

LUMBO/PELVIC/FEMORAL:

	YES	NO
Lower back pain	☐	☐
Scoliosis	☐	☐
Hip or Groin Pain	☐	☐
Lateral leg or ankle strain	☐	☐
History of foot/ankle sprains	☐	☐
Sense of one leg shorter or longer than the other	☐	☐
Frequent trips to the bathroom	☐	☐
Small amount of urine leakage with coughing, sneezing, exercising etc	☐	☐
Pain, discomfort or pressure in pelvic area with sitting or standing	☐	☐

Describe any traumas that led to your symptoms (i.e. MVA, falls etc.): _____

Have you had anything happen that affected your ability to walk unaided? (i.e. time in a boot or on crutches)

Is there anything else significant about your health history (physical or mental) that we should be aware of? (Feel free to attach other documentation or narratives if you feel they will be helpful to us): _____

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

III. PRIME Vision Information

Your visual system is strongly involved not only in the way you see objects (your clarity), but also in the way your brain orients you and balances you when you are upright and walking. Since we are looking at your posture when you are upright your visual system can be a big factor why you are having troubles, or as a treatment option for how we can help you improve your upright posture.

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

	YES	NO		YES	NO
Lazy eye/Strabismus	☐	☐	Double Vision	☐	☐
Intermittent Blurred Vision	☐	☐	Eye strain	☐	☐
Brain fog/Difficulty with Concentration	☐	☐	Difficulty with reading Comprehension	☐	☐
Pain behind eye(s)	☐	☐	Light sensitive	☐	☐
Hypersensitivity to sound Or movement	☐	☐	Occasionally bump into objects when walking	☐	☐
Dizziness	☐	☐	Balance Issues	☐	☐
Difficulty driving at night	☐	☐	Recent large changes in eye prescription	☐	☐
Eye Surgery (explain below)	☐	☐			
Vision therapy	☐	☐			

When was your last eye exam? (Make sure we get a copy of this exam): _____

Do you currently wear glasses?	☐ YES	☐ NO	When? _____
Do they have a Bifocal?	☐ YES	☐ NO	If yes... ☐ Lined ☐ Progressive
What age did you first need glasses?	_____		
Do you have difficulty at the computer?	☐ YES	☐ NO	
Number of hours per day on screens:	For work: _____	For Pleasure: _____	
Do you wear Contact Lenses?	☐ YES	☐ NO	When? _____
Are you, or have you been in Monovision?	☐ YES	☐ NO	

Describe any eye health issues we should know about (i.e surgery, glaucoma, detached retina etc.)? _____

IV. PRIME Podiatry Information

Getting information about your feet (including the pictures) helps us make decisions about what pieces of the PRIME program will be beneficial for you.

<u>Foot/Ankle Information:</u>	YES	NO	
Feel unstable in ankles	☐	☐	
Wear Specific Shoes	☐	☐	Which ones? _____
Have Orthotics/Insoles	☐	☐	What type? _____
Do you have to stand for work?	☐	☐	
Wear special shoes for any reason	☐	☐	If yes, explain: _____
Prefer not to wear shoes	☐	☐	
Shoe Size: _____			

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

V. PRIME Dental Information

The use of an occlusal orthotic is a big part of our program to assist your head and neck posture. This information (and the attached pictures) helps our staff understand more about your dental history to make decisions about how this may be a part of your program.

Answer Yes or No if applicable to you (now or in the past):

	YES	NO		YES	NO
Allergies (Latex, balloons)	☐	☐	Allergies (Metals)	☐	☐
Allergies (Acrylic)	☐	☐	Allergies (Seasonal)	☐	☐
Jaw popping/clicking	☐	☐	Injury to either jaw joint	☐	☐
History of Orthodontia	☐	☐	Implants, bridges, or partials	☐	☐
When? _____			Where? _____		
Currently wearing mouthpiece	☐	☐	Injury to teeth	☐	☐
What kind? _____			Wake up with sore teeth	☐	☐
Top or Bottom? _____			Discomfort in teeth or gums	☐	☐
Missing any permanent teeth	☐	☐	Mouth Breather	☐	☐
Which ones? _____			Cleft Lip/Palate	☐	☐
HIV/AIDS	☐	☐	Tongue Thrust	☐	☐
Hepatitis	☐	☐	Prior Myofunctional Therapy	☐	☐
Tonsils/Adenoids Removed	☐	☐			

Are you currently in **active** orthodontia? ☐ YES ☐ NO

If yes, braces or Invisalign? _____

Do you have any dental treatment planned in the next 12 months? ☐ YES ☐ NO

If yes, what type of treatment is planned? _____

If yes, when is treatment to be done? _____

If you have a current dental appliance, was it fabricated with the help of your PRI practitioner?

☐ YES ☐ NO

Other Dental issues you think we should be aware of: _____

Please explain any **YES** answers from above if they are not explained in other parts of this form: _____

Thank you for filling out this form. If you have any questions regarding the form, please feel free to contact us at primengagement@gmail.com or by phone at 402-467-4545. Please fax all completed forms and pictures to us at 402-467-4580 or e-mail to the above address. Once we have the information our staff will review your paperwork and get back to you to let you know what we feel our PRIME program can do for you!



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.