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:

Fax: 402-467-4580

Email: Primengagement@gmail.com

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prime BE ENGAGED™

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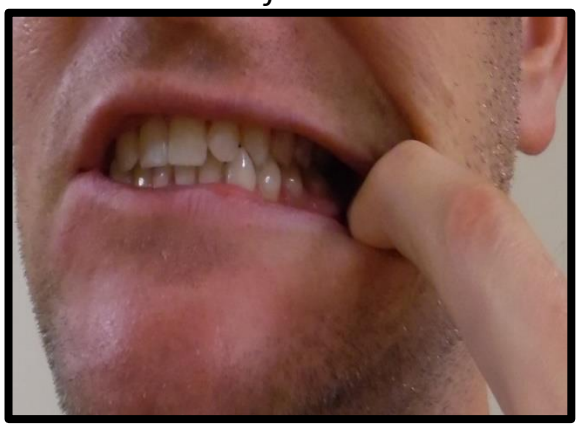
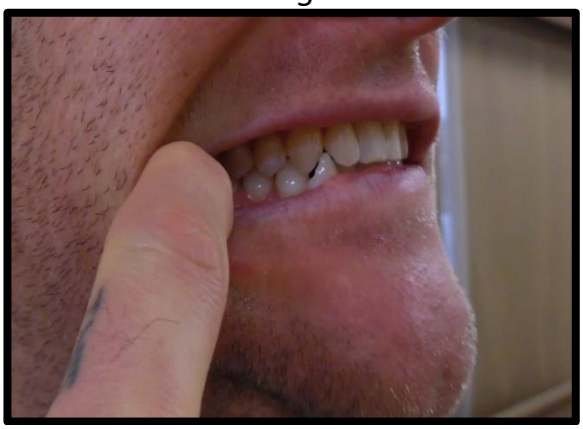
Dental and Foot Pictures of you we need: Feel free to attach or e-mail separately

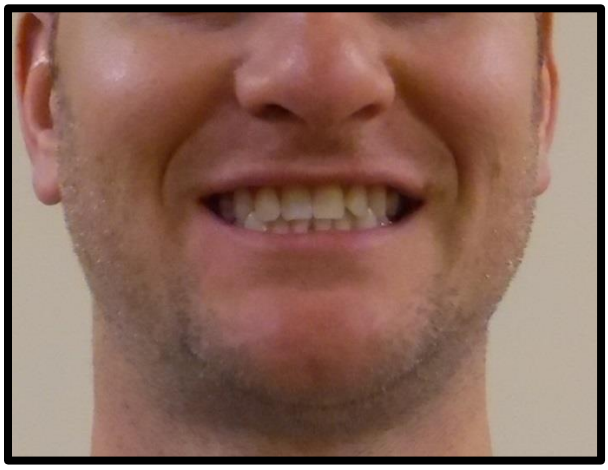
Left



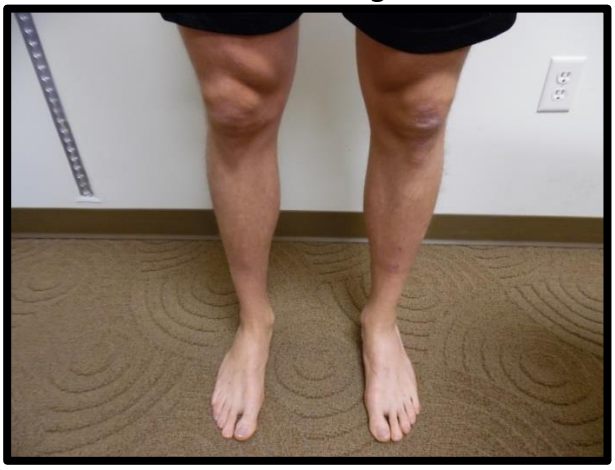
Right



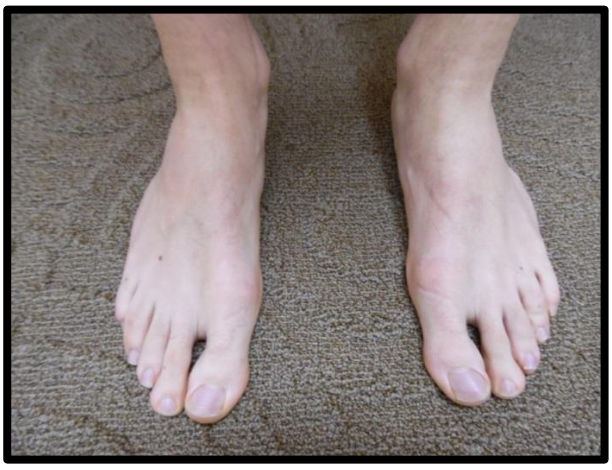
Front



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



Close Up in Same Position as 1st one



5241 R Street
Lincoln, NE 68504
Primengagement.com

Phone: 402-261-6793
Fax: 402-858-1037
primengagement@gmail.com

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

Heidi Wise, OD, FCOVD
Ron Hruska, MPA, PT
Paul Coffin, DPM
Rebecca Hohl, DDS, MS
Chris Campbell, DDS
David Drummer, DPT, PRC
Torin Berge, MPT, PRC
Lori Thomsen, MPT, PRC
Jason Masek, MSPT, CSCS, ATC, PRC
Caitlin Daubman, DPT, MHA

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:

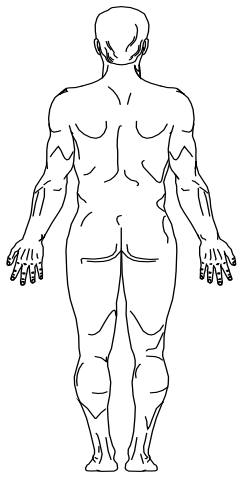
_____

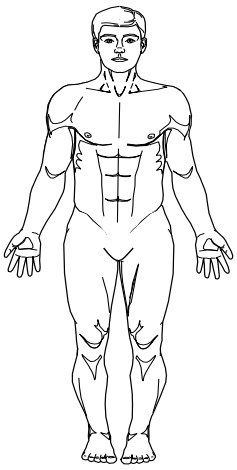
_____

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? _____

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

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?_____

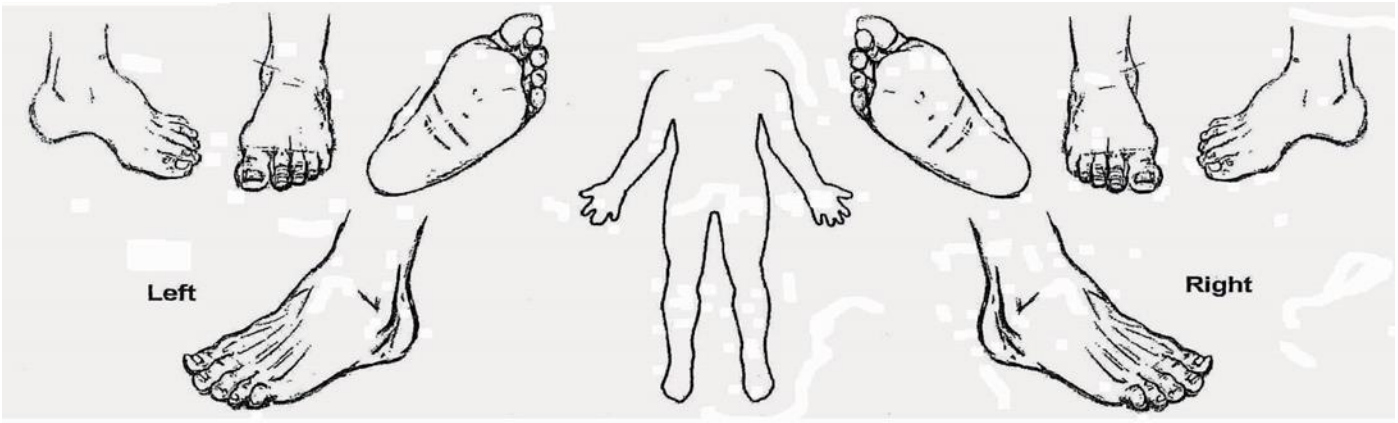
Heel Lift? _____ Other foot Inserts?_____

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	
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	
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 (acrylic)
Y N Allergies (food)
Y N Are you pregnant (females)
Y N Have OR have you had braces
Y N Jaw or facial pain
Y N Any teeth pulled
Y N Difficulty chewing or opening jaw
Y N Cysts or mouth infections
Y N Frequent clenching of teeth
Y N Injury to either jaw
Y N Injury involving teeth
Y N Thumb/finger sucking habit
Y N Frequently chews gum
Y N Speech therapy
Y N Wake up with sore jaw
Y N Any missing permanent teeth
Y N Bleeding gums
Y N Teeth that are shifting
Y N Any injuries to face, mouth, teeth
Y N Anemia
Y N Emotional problems
Y N HIV/AIDS
Y N Hepatitis
Y N Rheumatic fever
Y N Family history of cancer
Y N Ever been hospitalized
Y N Heart disease
Y N Enlarged tonsils
Y N Liver disease
Y N Tonsils/Adenoids removed
Y N Kidney disease
Y N Frequent sore throats
Y N Lung disease
Y N Cleft palate/lip
Y N Pneumonia
Y N Congenital heart defect
Y N Tongue thrust
Y N Growth problems
Y N Autism

Y N Allergies (metals-jewelry/clothing)
Y N Allergies (medication)
Y N Allergies (seasonal)
Y N Frequent headaches/migraines
Y N Presently wearing a mouthpiece
Y N Clicking, popping or jaw opening limitations
Y N Implants, bridges or partials
Y N Apprehensive about dental care
Y N Brush teeth daily
Y N Floss teeth daily
Y N Fluoride treatments
Y N Previous orthodontic therapy
Y N Frequent canker sores
Y N Had periodontal treatment
Y N Wake up with sore teeth
Y N Discomfort from teeth or gums
Y N Body piercing
Y N Sleeps with mouth open
Y N Gag reflux
Y N Mouth breathing
Y N Oral Surgery
Y N Hormone therapy
Y N Arthritis
Y N Radiation treatment
Y N Handicap/disabilities
Y N Requires premedication
Y N Tuberculosis
Y N Bone disorder/bone loss
Y N Tobacco use
Y N Immunodeficiency
Y N Bottle-fed
Y N Endocrine problems
Y N Breastfed
Y N Heart murmur
Y N Born premature (___weeks)
Y N Heart attack/stroke
Y N Hemophilia
Y N Frequent nausea
Y N Psychological counseling
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 out 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.