

When you have completed the forms, you can either print or save as pdf and fax or email them to our team at Fax: (650)-365-5986, or email to info@berkeprosthetics.com

Please Print All Information

Date

Last Name:

First:

Middle:

Date of Birth:

Age:

Sex: M F

E-Mail Address:

Patient's Address:

City:

State:

Zip:

Hm Phone:

Wk Phone:

Cell Phone:

Employer OR School Name:

Name of Responsible Party (if different than patient):

Address:

Phone:

Is your condition a result of an accident? Yes No

Is your condition a result of an accident from employment? Yes No

Date of accident:

State accident occurred in:

Referring Physician:

Phone:

Primary Physician:

Phone:

Physical Therapist:

Phone:

Person To Contact In Case of Emergency:

Address:

Phone:

Relationship To Patient:

Patient Medical History

Reason for Visit:

Allergies:

Height: Shoe Size: Activity Level: Low Medium High

Have you used any orthoses (braces) or prostheses in the past? Yes No

If so, please list device and date received:

Please list the dates and descriptions of past **relevant** surgeries:

Date	Description
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(use back side if necessary)

Please indicate your current medical conditions by selecting Yes or No:

Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Amputation	<input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Poor Circulation	<input type="radio"/> Yes <input type="radio"/> No
Heart disease	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Pregnant	<input type="radio"/> Yes <input type="radio"/> No		
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	If yes, where?	

Please List Below the Medications You Are Currently Taking:

(use back side if necessary)

Please describe your goals and expectations for your care here. (For example: pain reduction, ability to walk a certain distance, run etc...) This will allow your practitioner to better work with you toward a common goal. Please make sure you discuss this with your practitioner during your visit.

Financial Policy

Please review the following financial policy. We would be happy to answer any questions regarding your insurance payment issues.

Please remember our relationship is with you and not your insurance company. All charges are your responsibility. Your insurance carrier will only pay for services that it determines to be “reasonable and necessary” which may not be in keeping with the necessities of your health care.

We are happy to discuss with you all fees prior to provision of services.

We accept Cash, Checks and Credit Cards. Returned checks are subject to a 20.00 service charge.

I authorize my insurance benefits to be paid directly to Gary M. Berke MS, CP and I am financially responsible for all non-covered services.

I have read and understand the above policy.

Patient (or guardian) Signature

Date

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PROMIS-29 Profile v1.0

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 1	Are you able to do chores such as vacuuming or yard work?	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
PFA21 2	Are you able to go up and down stairs at a normal pace?	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
PFA23 3	Are you able to go for a walk of at least 15 minutes?	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
PFA53 4	Are you able to run errands and shop?	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1

Anxiety

In the past 7 days...

		Never	Rarely	Sometimes	Often	Always
EDANX01 5	I felt fearful	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
EDANX40 6	I found it hard to focus on anything other than my anxiety	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
EDANX41 7	My worries overwhelmed me	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
EDANX53 8	I felt uneasy	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

Depression

In the past 7 days...

		Never	Rarely	Sometimes	Often	Always
EDDEP04 9	I felt worthless	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
EDDEP06 10	I felt helpless	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
EDDEP29 11	I felt depressed	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
EDDEP41 12	I felt hopeless	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

Fatigue

During the past 7 days...

		Not at all	A little bit	Somewhat	Quite a bit	Very much
HI7 13	I feel fatigued	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
A3 14	I have trouble <u>starting</u> things because I am tired	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

In the past 7 days...

FATEXP41 15	How run-down did you feel on average?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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PROMIS-29 Profile v1.0

Fatigue

In the past 7 days...

		Not at all	A little bit	Somewhat	Quite a bit	Very much
FATEXP40 16	How fatigued were you on average?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

Sleep Disturbance

In the past 7 days...

		Very poor	Poor	Fair	Good	Very good
Sleep109 17	My sleep quality was...	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1

In the past 7 days...

		Not at all	A little bit	Somewhat	Quite a bit	Very much
Sleep116 18	My sleep was refreshing	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1

Sleep20 19	I had a problem with my sleep	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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Sleep44 20	I had difficulty falling asleep	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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Satisfaction with Social Role

In the past 7 days...

		Not at all	A little bit	Somewhat	Quite a bit	Very much
SRPSAT07 21	I am satisfied with how much work I can do (including work at home)	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

SRPSAT24 22	I am satisfied with my ability to work (including work at home)	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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SRPSAT47 23	I am satisfied with my ability to do regular personal and household responsibilities	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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SRPSAT49 24	I am satisfied with my ability to perform my daily routines	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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Pain Interference

In the past 7 days...

		Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ9 25	How much did pain interfere with your day to day activities?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

PAININ22 26	How much did pain interfere with work around the home?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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PAININ31 27	How much did pain interfere with your ability to participate in social activities?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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PAININ34 28	How much did pain interfere with your household chores?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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Pain Intensity

In the past 7 days...

		No pain									Worst imaginable pain	
Global07 29	How would you rate your pain on average?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10