PAIN MANAGEMENT ASSISTANCE PROGRAM

PAIN MAP

Providing free physical therapy services to low income & uninsured patients with persistent pain conditions.

Eligibility & Application Requirements:

- Applicants must have a persistent pain condition (i.e. any condition that causes pain for 3 months or longer).
- Applicants must be currently uninsured and/or underinsured and low income.
- Applicants will only be accepted on a first-come, first-served basis while funding is available.
- Those accepted will receive a wellness scholarship entitling them to up to six weeks of 100% free physical therapy services (including therapeutic exercise, neuromuscular re-education, health and wellness education, and manual therapy as deemed medically necessary), with no obligation or pressure to purchase additional paid services.
- In return, Patient PT asks *only* that program participants agree to make a good-faith best effort to follow all instructions provided and communicate openly about obstacles, allow up to two hours for each visit, and agree to complete surveys and objective measures of progress as requested, the results of which will be used for ongoing research and development of the Pain MAP program.

Please email patientphysicaltherapy@gmail.com with the subject line "Pain MAP," to request more information or apply, or call / text 812.558.0708.

patient PHYSICAL THERAPY

Executive Park North
2620 N Walnut Street
Bloomington, IN 47404
suite 600

http://patientphysicaltherapy.com • patientphysicaltherapy@gmail.com • 812.558.0708

All information provided on this form will be kept confidential.

PAIN MANAGEMENT ASSISTANCE PROGRAM

Application & Eligibility Requirements

PLEASE COMPLETE AND RETURN TO:

Patient PT
2620 N Walnut St, Suite 600
Bloomington, IN 47408
patientphysicaltherapy@gmail.com
812.558.0708

Pain Management Assistant Program (Pain MAP) is a voluntary informal research program offered by Patient PT, which is designed to provide free and/or sliding scale physical therapy services to people from disadvantaged circumstances while learning more about how persistent pain conditions and other chronic health disorders can be managed through education, preventative maintenance, and wellness promotion.

Pro-bono and sliding-scale services will be offered to eligible applicants on a first-come, first-served basis and only as funding levels allow. After completing this form please return it to Patient PT, where it will be evaluated to determine eligibility for either sliding-scale or free services. Applicants will be notified of eligibility status and availability of funds via email, and should ensure patientphysicaltherapy@gmail.com is included in their email address book to avoid lost communications. If you have already applied for this program and did not receive a response, please call 812.558.0708.

_____ _____
Client Name Date

_____ _____
Address Date of Birth

_____ _____
City State Zip Preferred email address

_____ _____
Occupation Phone Number (Cell ☐)

Do you have a chronic pain diagnosis, persistent pain, or long-term recurring pain? ☐ Yes ☐ No

If yes, how often do you experience this pain? (circle one)

Once a month or less 1-3 times per month Weekly

1-3 times per week 3+ times per week Every day

Are you in pain right now? ☐ No ☐ Yes: please rate on a scale of 1-10 ____/10

How long ago did you first have this pain? (circle one)

< 1 month 1-3 Months 3-6 Months 6-12 Months 1-3 Years 3+ Years

All information provided on this form will be kept confidential.

Does this pain currently limit your ability to…. (check all that apply)

- ☐ Walk for as long as you need to
- ☐ Climb stairs
- ☐ Do housework
- ☐ Dress or groom yourself
- ☐ Care for children or other dependents
- ☐ Lift and/or carry objects
- ☐ Run errands, grocery shop
- ☐ Drive
- ☐ Work
- ☐ Socialize / Participate in recreation (social activities, exercise, hobbies, sports)
- ☐ Other:

_____

What else (if anything) have you already tried in order to manage this pain? (check all that apply)

- ☐ Physical Therapy
- ☐ Massage
- ☐ Chiropractic Care
- ☐ Consult Physician or Pain Specialist
- ☐ Over-the-counter pain relievers (Tylenol, ibuprofen, aleve, etc)
- ☐ Topical pain relievers or numbing agents (Aspercreme, Icy Hot, etc)
- ☐ Prescription pain relievers
- ☐ Prescription muscle relaxers
- ☐ Yoga
- ☐ Meditation
- ☐ Strength Training
- ☐ Stretching
- ☐ Ice or Heat
- ☐ Posture Training
- ☐ Other:

_____

Have you lost income as a result of this pain? ☐ Yes ☐ No

Do you have health insurance of any kind? ☐ Yes ☐ No

What is your current household income?

How many people currently share your residence?

Please describe what you hope to gain or achieve by working with Patient PT:

All information provided on this form will be kept confidential.

How did you hear about Patient PT? ☐ Sign/Flyer/Ad ☐ Social Media ☐ Internet search

☐ Referral: _____ ☐ Other: _____

Please read the following statements carefully and check each box to show that you have read and understood the terms and expectations of participating in the Pain Management Assistance Program.

☐ I understand that physical therapy is a team process that requires both the patient (myself) and the physical therapist to invest time and energy.
☐ I understand that Patient PT will rely on subjective pain scales (my own 1-10 pain ratings) and other information I provide to guide my treatment, and I will report my symptoms and concerns promptly and to the best of my ability.
☐ I will make a good faith effort to complete my home exercises and other tasks as prescribed by my physical therapist and communicate any difficulties I am having as they arise to help ensure my own success.
☐ I am ready and willing to commit to doing everything reasonably within my power to take charge of this problem and learn how to cope with it to the best of my ability under the supervision and guidance of Patient PT, LLC.
☐ I understand that as part of this program I will be required to fill out surveys and answer questions regarding my abilities, attitudes, and beliefs that will then be used to gauge my progression over time.
☐ I understand that all non-personally identifying information gathered during my participation in this program will be used to develop and improve the program itself and other offerings at Patient PT, LLC, some of which may later be made commercially available.
☐ I understand that information regarding my personal identity including my likeness will be kept confidential, unless I am asked and agree to sign a separate release for the use of this information.

_____ _____
Signature Date

_____
Printed Name

This portion of the form to be completed by the evaluating clinician only

Reviewed By:

_____ _____
Kelly Clark, DPT, PT, MT Date