Referring Clinician:_____
Email:_____
Phone#:_____
Fax #: _____
Clinician Permission to Contact Patient Directly Y/N

Patient Name:_____
Email:_____
Phone#:_____
DOB:_____

Hruska Clinic Triage Form

PRI Information

What are the top three musculoskeletal pain patterns of the patient?

_____

_____

Why is this patient being referred to the Hruska Clinic? (i.e. does the referring physical therapist need direction with dental concerns, visual/vestibular concerns)

_____

_____

Has the patient been through a PRI program? Yes/No

If yes, what is their habitual pattern?

____ AIC (Left or Bilateral) ____ BC (Right or Bilateral) ____ PEC ____ TMCC

____PRI Tests that are pathologic:_____

Has this (PRI) patient ever been able to achieve neutrality at the:

Pelvis Yes/No If yes, are they able to maintain neutrality? Yes/No
Brachial Chain Yes/No If yes, are they able to maintain neutrality? Yes/No
Neck Yes/No If yes, are they able to maintain neutrality? Yes/No

If yes, under what conditions? (Please clarify in the space provided)

____Non-Manual Techniques ____Manual Techniques ____Change of footwear
____PRI Orthotics ____Oral Appliance ____ Other (i.e Change of visual input)

_____

_____

_____

Previous surgery? Yes/No If yes, please specify. _____

Are they undergoing any other PRI-directed treatment, such as dental/orthodontic work, vision training? Yes/No If yes, what care? _____

Do they have a history of (Please circle all that apply):

Trauma Concussions? Cervical Injuries? Headaches?
Dizziness/Vertigo? (Has this been resolved? Yes/No)

Patient's Hand Dominance: Right-handed Left-handed

Anything else significant about this patient's history that would reflect the need for the patient to be seen by a PRI certified therapist from the Hruska clinic.

_____

_____

_____

Prior PRI (or other) Treatments and Current Status:

(Include other details, i.e. type of appliance used, lift scores etc.)