



Date _____

Patient Name _____ Date of Birth _____

Address _____ Zipcode _____

Home Phone # _____ Cell Phone # _____ Marital Status _____

S.S.# _____ - _____ - _____ Driver's License # _____

E-mail Address _____ Referred by: _____

Employer _____ Office Phone# _____

Employer Address _____ Occupation _____

Spouse/Responsible Party _____ Phone # _____

Employer _____ Occupation _____

Primary Insurance _____ ID# _____ Grp# _____

Secondary Insurance _____ ID# _____ Grp# _____

Is this a worker's compensation injury? YES/ NO If yes, date of injury _____

Employer at time of injury _____ Phone # _____

Worker's comp. Insurance Carrier _____ Claim # _____

Is this an auto accident? YES/ NO If yes, date of accident _____

Insured's name _____ Policy # _____

Auto Insurance Carrier _____ Phone # _____

Is this a liability or legal case? YES/ NO If yes, please provide attorney information: _____

Emergency Contact _____ Phone # _____

Relationship _____ Address _____

The following persons are allowed to receive and/or review all my medical records, reports and appointments associated with my treatment. Those who I authorize are:

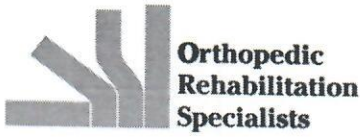
- 1. _____ 2. _____ 3. _____

I authorize any insurance carrier, employer, hospital or physician to release any information requested with regard to my current physical condition. This authorization shall remain in effect until my course of treatment is completed or it is revoked by me in writing. A photocopy of this is to be considered as valid as the original.

PATIENT SIGNATURE / RESPONSIBLE PARTY

Patient/ Guardian Signature: _____ Relationship to Patient _____

Print Patient Name: _____ Date: _____



**Orthopedic
Rehabilitation
Specialists**

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: ___/___/___ HEIGHT _____ WEIGHT _____ L - HANDED - R

Marital Status: _____ # Children _____ Ages _____ Currently Working Y N

Occupation _____ Referring MD _____

Is your present problem related to: Illness _____ Accident _____ Work-Related _____

Please indicate for which body region(s) are you seeking treatment: (Please Circle)

Neck Mid Back Low Back Shoulder Elbow Hand Wrist Hip
Knee Ankle/foot Other _____

When did your symptoms start? _____

Can you identify a cause for your symptoms? Y N

If yes, specify _____

Have you ever had similar symptoms in the past? Y N

If yes, when? _____

Have you recently had the following tests? (Circle all that apply):

X-Rays CT Scan MRI Bone Scan Blood Tests EKG Echocardiogram

Stress Test EMG Pulmonary Function Test Myelogram

Pain rating: Indicate your average level of pain by CIRCLING the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10
Pain Free Most Severe

Have you seen anyone else for this problem? (Circle all that apply)

Physician Physical Therapist Chiropractor Osteopath Podiatrist

Dentist Psychologist/Psychiatrist Other

NAME: _____

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Describe the character of your **pain**: (Does it feel... sharp, dull, achy, etc.?) _____

Is your pain worse in the **am** _____ **pm** _____?

Is the pain there all the time? **Y** **N**

Do you have numbness, tingling, or weakness? **Y** **N** Location? _____

Have you had any recent changes in your bowel, bladder or sexual function? **Y** **N**

What activities/positions make your pain **worse**? _____

What activities/positions make your pain **better**? _____

HAVE YOU:	IF YES, EXPLAIN:	
Experienced any trauma (i.e. motor vehicle accident or fall from a height)?	YES	NO _____
Experienced any head trauma / brain injury?	YES	NO _____
Experienced an inability to focus or concentrate recently?	YES	NO _____
Experienced unusual clumsiness or lack of coordination?	YES	NO _____
Had open wounds / redness / cuts / infection recently?	YES	NO _____
Experienced unexplained back or flank pain?	YES	NO _____
Experienced groin/hip/thigh aching or pain that increases with activity?	YES	NO _____
Sustained a blow or trauma to any body part?	YES	NO _____
Recently begun an exercise program or modified an existing program?	YES	NO _____
Taken a long car ride / bus trip /plane ride?	YES	NO _____

PLEASE PROVIDE A LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	Dosage	Frequency	How Taken (oral, injection, etc.)

NAME _____

Have you ever suffered from or been told that you have:	YES	NO	Therapist Comments:
High blood pressure			
Thyroid problems			
Diabetes (high blood sugar)			
Osteoporosis			
Circulation or vascular problems			
Seizures / Epilepsy			
Recent / Repeated Infections			
Arthritis / Rheumatoid Arthritis / Gout			
Kidney problems			
Cancer			
Head injury / Headaches			
Heart problems / Pacemaker			
Lung / Respiratory problems / Asthma			
Multiple Sclerosis / Parkinson's Disease			
Stroke / Neurological problems			
Liver Problems / Hepatitis			
Blood disorders / Blood Clots			
Low blood sugar			
Tuberculosis			
Broken bones (fractures)			
Ulcers / stomach problems			
Allergies			
FOR WOMEN ONLY:			
Pelvic inflammatory disease			
Endometriosis			
Any complicated pregnancies or deliveries			
Trouble with your period			
Are you or could you be pregnant?			
FOR MEN ONLY:			
Prostate Disease			
HAVE YOU RECENTLY HAD:			
Unexplained Weight Loss/ Gain			
Fatigue / Tiredness / Malaise			
Diarrhea / Constipation / Incontinence			
Frequent Urination			
Blood in Stool or Urine			
Unexplained fever or chills / sweating			
Shortness of breath / Difficulty Breathing			
Cough / Hoarseness			

HAVE YOU RECENTLY HAD:	YES	NO	Therapist Comments:
Unexplained fever or chills			
Visual problems / Loss of Vision			
Joint Pain and/or Swelling			
Difficulty Walking			
Nausea / Vomiting			
Numbness or tingling			
Weakness in your arms or legs			
Difficulty swallowing			
Pain at rest			
Pain at night			
New Onset of Headaches			
Hearing Problems			
Loss of appetite			
Chest Pain			
Heart palpitations / Heart Racing			
Dizziness or Loss of Consciousness			
Loss of balance / Any Recent Falls			
Implants / Metal Implants			
Difficulty Sleeping			
DO YOU:			
Smoke?			
If yes, how much? (packs per day)			
Have any significant family history of illness/ disease?			
Have any other medical problems?			
HAVE YOU:			
Had surgery or been hospitalized in the past?	YES	NO	If yes, please explain below
A.	REASON:		DATE:
B.	REASON:		DATE:
C.	REASON:		DATE:
Who is your primary doctor, or the doctor you see most often?			
When was your last general check-up?			DATE:

Please describe your job/social activities and your current ability to perform them:

What do you want to accomplish from your course of Physical Therapy Treatment?

Is there anything else you feel is important to tell me?

Name: _____ **Signature:** _____



**Have you had any type of therapy (OT,
PT, Speech or Chiropractic) during
20__ *other than* in our office.**

YES *if so:*

When _____

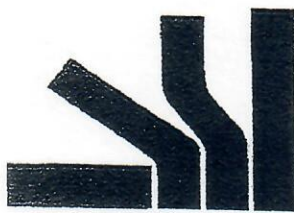
Where _____

How Many Visits _____

NO

Patient Name: _____

Date: _____



**Orthopedic
Rehabilitation
Specialists**

Hand Crafted Physical Therapy

Patient Name: _____ Date: _____

Are you currently receiving Home Health Care?

YES _____ NO _____

Have you had any type of Home Care Services?

YES _____ NO _____

If yes, provide us with your Discharge date:

X _____

Name: _____

	Activity/Function/Skill	Able	Unable	Prior Level of Function (Before Illness/Injury)
1	Rolling over in bed			
2	Getting out of bed			
3	Sitting			
4	Standing			
5	Transfer to/from bath			
6	Getting up from chair			
7	Transfer to/from car			
8	Reaching - level/overhead			
9	Bathing/Showering			
10	Dressing			
11	Grooming			
12	Using Telephone			
13	Walking			
14	Going down stairs			
15	Going up stairs			
16	Stooping/Squatting			
17	Lifting			
18	Carrying			
19	Meal preparation			
20	Driving			
21	Child Care			
22	Household cleaning			
	List Other Activities Affected by Your Symptoms: Sports, Hobbies, Etc.			

Job Description/Social Activities and Ability to Perform Them: _____

What Do You Want to Accomplish from your Course of Physical Therapy Treatment? _____

Patient Signature: _____

ELDER ABUSE SUSPICION INDEX © (EASI)

EASI Questions

Q.1-Q.5 asked of patient; Q.6 answered by Therapist (within the last 12 months)

Patient Name: _____

Date: _____

- | | | | |
|--|-----|----|----------------|
| 1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? | YES | NO | Did not answer |
| 2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with? | YES | NO | Did not answer |
| 3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened? | YES | NO | Did not answer |
| 4) Has anyone tried to force you to sign papers or to use your money against your will? | YES | NO | Did not answer |
| 5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? | YES | NO | Did not answer |

6) **Therapist:** Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?

YES NO Not sure

Name: _____ Date: _____

PHQ- 9 TEST

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all Several days More than half the days Nearly every day

0 1 2 3

1 Little interest or pleasure in doing things

2 Feeling down, depressed, or hopeless

0 1 2 3

3 Trouble falling or staying asleep, or sleeping too much

0 1 2 3

4 Feeling tired or having little energy

0 1 2 3

5 Poor appetite or overeating

0 1 2 3

6 Feeling bad about yourself — or that you are a failure or have let yourself or your family down

0 1 2 3

7 Trouble concentrating on things, such as reading the newspaper or watching television

0 1 2 3

8 Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

0 1 2 3

9 Thoughts that you would be better off dead or of hurting yourself in some way

0 1 2 3

(add Columns) + + =

A11 – PHQ9 TOTAL SCORE _____

FINANCIAL AGREEMENT

I hereby assign all medical benefits, including major medical benefits, to which I am entitled including Medicare, private insurance and any other health plans or insurance coverage to Orthopedic Rehabilitation Specialists, Inc., including any settlements from lawsuit. Please remember that verification of insurance benefits is not a guarantee of payment. I am responsible for the remaining balance, including deductibles, and non-covered expenses. If for any reason the account is assigned to an attorney for collections and/or lawsuit, Orthopedic Rehabilitation Specialists Inc. will be entitled to reasonable attorney's fees and cost of collections. To the extent necessary to determine liability of our payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical/financial record. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I authorize Orthopedic Rehabilitation Specialists Inc. to release all information necessary to secure payment.

CANCELLATION POLICY

I understand that it is my responsibility to keep scheduled appointments. Failure to cancel with 24 hours notice will result in a \$40.00 administration fee. Failure to notify our office may result in a full day visit charge.

CONSENT, USE, DISCLOSURE AND ACKNOWLEDGEMENT OF HEALTHCARE AND PRIVACY PRACTICES

I have had full opportunity to read and consider the contents of the Consent form and the posted Notice of Privacy Practices. Understand that by signing this form I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

INFORMED CONSENT FOR PHYSICAL THERAPY

Physical therapy involves the use of many different types of physical evaluation and treatment. At Orthopedic Rehabilitation Specialists, we use a variety of procedures and modalities to help us to try to improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

The physical responses to a specific treatment can vary widely from person to person. It is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee that our treatment will help the condition for which you are seeking treatment. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis(es), symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risk(s) associated with your exercise(s), your therapist will be glad to answer them.

I acknowledge and understand the statement above. I understand that my treatment program will be explained to me by Orthopedic Rehabilitation Specialists, and that I am able to ask any question or state any concerns. I understand the risks associated with a program of Physical Therapy as outlined to me, and I authorize treatment.

Patient Name (Printed): _____ Date: _____

Patient Signature: _____ Guardian (if under 18) _____

