**Orthopedic Rehabilitation Specialists**

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: _____

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

☐ **YES *if so*:**

**When**_____

**Where**_____

**How Many Visits**_____

☐ **NO**

**Patient Name:**_____

**Date:**_____

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**PATIENT'S NAME:** _____ **TODAY'S DATE:** _____

DATE OF BIRTH: ____/____/____ HEIGHT _____ WEIGHT _____ **L** – HANDED – **R**

Parent's Name: _____ Number of siblings _____ Ages _____

Referring MD _____

**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 symptoms start? / When did signs were first noticed?** _____

**Can you identify a cause for signs and or symptoms? Y N**

**If yes, specify** _____

**Has the patient shown similar symptoms in the past? Y N**
**If yes, when?** _____

**Has the patient recently had any diagnostic tests? If yes, which ones and what date. (Please include any visual, hearing test?**

| Test | Date | Results | Treatments/ Management |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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**PATIENT'S NAME:** _____

**If the patient/ child is able to identify a pain level, please indicate below.**

**Pain rating: Indicate 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**

**Has the patient/ child been to anyone else for this problem? (Circle all that apply)**

*Physician/ Pediatrician* *Physical Therapist* *Neurologist* *Orthopedic*

*Other:*

**Has your child received any treatments for the current condition or other conditions (Example Occupation Therapy, Physical Therapy, Speech Therapy, Behavioral therapy, or other)?. If currently receiving any form of treatment, please indicate as ongoing under End date.**

| Service | Reason | End date | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Does your Child attend daycare or school? Y N**

**Does your child perform any other activities/ sports? Y N**

**If yes, please explain:** _____

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**PATIENT'S NAME:** _____

**The purpose of this questionnaire is to help us understand the child's medical and developmental history including Mother's pregnancy and delivery. Please complete this form and your therapist will answer any questions during the evaluation. This form is considered part of the patient's medical record.**

Please describe your main concern: _____

What was the length of pregnancy? _____

Were there any complications during pregnancy? **Y** **N**

If yes, please explain: _____

Were there any complications during Delivery? **Y** **N**

If yes, please explain: _____

Delivery method: _____

Mother's age at the time of Delivery: _____

Child's weight and length at the time of Delivery: _____

**PLEASE PROVIDE THE AGE FOR WHEN DEVELOPMENTAL MILESTONES WERE FIRST OBSERVED**

| MILESTONE | Age | Comments/ concern |
|---|---|---|
| Crawling | | |
| sitting | | |
| Standing | | |
| Walking | | |
| Other: | | |
| | | |

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**NAME**_____

| **Has your child suffered from/ been diagnosed with/ or experience any of the following:** | **YES** | **NO** | **Comments:** |
|---|---|---|---|
| Allergies | | | |
| Recent / Repeated Infections | | | |
| Kidney problems | | | |
| Cancer | | | |
| Head injury / Headaches | | | |
| Heart problems | | | |
| Lung / Respiratory problems / Asthma | | | |
| Neurological problems | | | |
| **HAS YOUR CHILD RECENTLY HAD:** | | | |
| Unexplained Weight Loss/ Gain | | | |
| Diarrhea / Constipation / Incontinence | | | |
| Frequent Urination | | | |
| Blood in Stool or Urine | | | |
| Fever | | | |
| Cough | | | |
| Vomiting | | | |
| Difficulty swallowing | | | |

| **HAS YOUR CHILD** | | | |
|---|---|---|---|
| Had surgery or been hospitalized in the past? | YES | NO | If yes, please explain below |
| A. | REASON: | | DATE: |
| B. | REASON: | | DATE: |
| C. | REASON: | | DATE: |
| When was the last general check-up? | | | DATE: |

**Please describe any activities you have observed your child has difficulty with.**

_____

**Please describe any positions or activities you have observed your child prefers.**

_____

**What do you want to accomplish from Physical Therapy Treatment?**

_____

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

_____

**Name:** _____ **Signature:** _____

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HAND-CRAFTED PHYSICAL THERAPY



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 Accompllish from your Course of Physical Therapy Treatment? _____

_____

_____

Patient Signature:_____

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## 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)_____