

PATIENT INFORMATION

Patient's Legal Name _____ Social Security # _____ Sex M F
Birth Date _____ Age _____ Marital Status: Married Single Widowed Divorced Separated
Mailing Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
Do we have permission to leave a message on your phone? Yes No
Text or email appointment reminders? Yes No Email: _____
Have you received home health services in the last 60 days? Yes No
List other providers you are treating with (excluding your MD): _____

SPOUSE, PARENT/LEGAL GUARDIAN & EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Birth Date _____ Sex M F
Work # _____ Cell # _____
Place of Employment _____ Occupation _____
In case of emergency, please contact: _____ Relationship _____
Home # _____ Work # _____ Cell # _____

ACCIDENT INSURANCE INFORMATION

PLEASE COMPLETE: **Work Related** Yes No **Auto Accident** Yes No **Other Accident** Yes No
Accident Insurance _____ Claim # _____
Adjuster's Name & Phone Number _____
Date of Accident _____ Describe _____

HEALTH INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____
Subscriber's Name _____ Subscriber's Name _____
Birth Date of Policy Holder _____ Birth Date of Policy Holder _____

ADDITIONAL INFORMATION

Place of Employment _____ Occupation _____
Family Physician _____ Referring Physician _____

I understand that should I default on payment of this account and collection agency services are required, all costs of collection including attorney fees will be added to the balance of said account.

Signature _____ Date _____

PLEASE PRESENT YOUR PHOTO ID & HEALTH INSURANCE CARD(S) TO OUR FRONT DESK PERSONNEL

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I understand that:

- As part of my health care, Orthopedic Rehab Inc. originates and maintains health records describing my health history, symptoms, examinations, diagnoses and treatment.
- The use and disclosure of my protected health information (PHI) by Orthopedic Rehab Inc. is necessary in order to provide my medical care, and is also necessary for Orthopedic Rehab Inc. to obtain payment for my treatment and to carry out the practice's health care operations.
- I have the option to receive a copy of **Orthopedic Rehab Inc.'s Notice of Privacy Practices** which provides a more complete description of the use and disclosure of my health information, and that I have the right to review that Notice prior to signing this consent. I also understand that Orthopedic Rehab Inc. reserves the right to change the Notice and its privacy practices at any time and that if I request, Orthopedic Rehab Inc. will mail me a copy of any revised Notice prior to its implementation.

I give Orthopedic Rehab Inc. permission to talk to the following person/people regarding my account and health information:

NAME:

RELATIONSHIP TO PATIENT:

CANCELLATION AND NO SHOW POLICY

Your appointments are reserved especially for you and are very important to the OrthoRehab team. We understand that sometimes schedule changes are necessary and therefore, we respectfully request at least 24 hour notice for cancellations or rescheduling of appointments. Because of the busy nature of our office, 24 hour notice allows us time to offer your appointment to another patient.

Missed scheduled appointments, without providing 24 hour advance notice, will be charged a \$25 fee.

ASSIGNMENT OF BENEFITS AND INSURANCE DISCLAIMER

I authorize my health insurance to make payment of medical benefits directly to Orthopedic Rehab Inc. I understand that I am liable for any charges incurred should my insurance or the liable party's insurance deny payment for ANY reason.

Although Orthopedic Rehab Inc. contracts with most insurance providers, they bill my insurance as a courtesy to me. I will provide all pertinent and related insurance information, including any accident, automobile, liability, and or health insurance. Orthopedic Rehab Inc. reserves the right to lien patient recoveries from legal or insurance settlements for unpaid charge when permitted by law. Orthopedic Rehab Inc. will not bill attorneys for any claims.

I am responsible for knowing what my medical and outpatient physical therapy benefits are. **I agree to pay any co-payments, co-insurance, and deductibles at the time of service.** I understand that should my balance exceed 90 days, a finance charge will begin to accrue.

Orthopedic Rehab Inc. will arrange a payment plan and/or assist me with Care Credit, when necessary. Unless payment arrangements are made with Orthopedic Rehab Inc., past due balances will be sent to an outside collections agency. I understand that should I default on payment of my account and collection agency services are required, all costs of collection including attorneys will be added to the balance of my account.

PATIENT OR GUARANTOR SIGNATURE

DATE

Medical History

NAME: _____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____

WHAT EASES YOUR PAIN? _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT ARE YOUR GOALS IN PHYSICAL THERAPY?

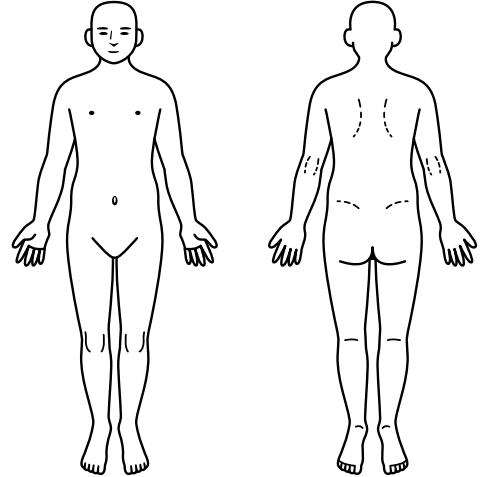
HAVE YOU HAD PREVIOUS TREATMENT FOR THIS PROBLEM?

PLEASE SPECIFY: PT CHIROPRACTIC OTHER _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS?

X-RAY CT SCAN MRI EMG

Please mark the areas of your pain here:



Please mark any of the following past and current conditions that apply to you (*be as thorough as possible*):

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Allergies			Dizzy Spells			MRSA		
Anemia			Emphysema/Bronchitis			Multiple Sclerosis		
Anxiety			Fibromyalgia			Muscular Disease		
Arthritis			Fractures			Osteoporosis		
Asthma			Gallbladder Problems			Parkinsons		
Autoimmune Disorder			Headaches			Rheumatoid Arthritis		
Cancer			Hearing Impairment			Seizures		
Cardiac Conditions			Hepatitis			Smoking		
Cardiac Pacemaker			High Cholesterol			Speech Problems		
Chemical Dependency			High/Low Blood Pressure			Strokes		
Circulation Problems			HIV/AIDS			Thyroid Disease		
Currently Pregnant			Incontinence			Tuberculosis		
Depression			Kidney Problems			Vision Problems		
Diabetes			Metal Implants					

Please explain any of the above marked "Yes" and describe any additional conditions or precautions:

Injury a result of a fall in the past year? YES NO Have you had two or more falls in the last year? YES NO

Please describe **all surgeries** or hospitalizations (*continue on back side if necessary*):

SURGERY TYPE: **DATE (mm/yyyy):**

Please list **all medications** you are currently taking (*continue on back side if necessary*):

MEDICATION	DOSAGE	FREQUENCY	ROUTE	REASON TAKING

SIGNATURE: _____

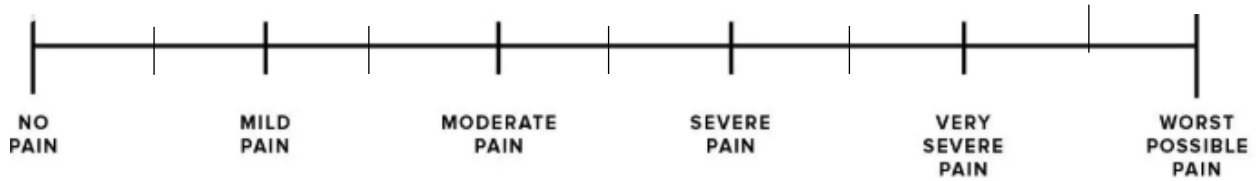
DATE: _____

Name: _____ DOB: _____ Date: _____

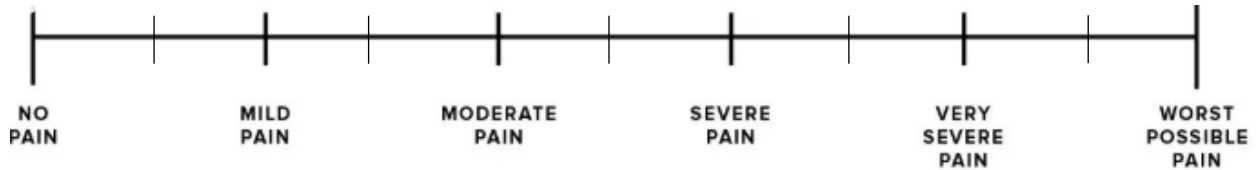
Pain Scale

Please circle to indicate your level of pain.

Pain with Movement



Pain at its Worst



Please circle the number that best fits.

Over the past 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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Modified Oswestry Low Back Disability Questionnaire

Patient Name: _____ Date: _____

<p>Section 1 – Pain Intensity</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can tolerate the pain I have without having to use pain medication. <input type="checkbox"/> The pain is bad, but I can manage without having to take pain medication. <input type="checkbox"/> Pain medication provides me with complete relief from pain. <input type="checkbox"/> Pain medication provides me with moderate relief from pain <input type="checkbox"/> Pain medication provides me with little relief from my pain <input type="checkbox"/> Pain medication has no effect on my pain. 	<p>Section 6 – Standing</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can stand as long as I want without increased pain. <input type="checkbox"/> I can stand as long as I want but it increases my pain. <input type="checkbox"/> Pain prevents me from standing for more than 1 hour. <input type="checkbox"/> Pain prevents me from standing for more than ½ an hour. <input type="checkbox"/> Pain prevents me from standing for more than 10 minutes. <input type="checkbox"/> Pain prevents me from standing at all.
<p>Section 2 – Personal Care (IE: Washing, Dressing)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can take care of myself normally without causing increased pain. <input type="checkbox"/> I can take care of myself normally, but it increases my pain. <input type="checkbox"/> It is painful to take care of myself, and I am slow and careful. <input type="checkbox"/> I need help, but I am able to manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of my care. <input type="checkbox"/> I do not get dressed, I wash with difficulty, and stay in bed. 	<p>Section 7 – Sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> My sleep is never disturbed by pain. <input type="checkbox"/> I can sleep well only using pain medication. <input type="checkbox"/> Even when I take medication, I sleep less than 6 hours. <input type="checkbox"/> Even when I take medication, I sleep less than 4 hours. <input type="checkbox"/> Even when I take medication, I sleep less than 2 hours. <input type="checkbox"/> Pain prevents me from sleeping at all.
<p>Section 3 – Lifting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without increased pain. <input type="checkbox"/> I can lift heavy weights, but it causes increased pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (IE on a table) <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift only very light weights. <input type="checkbox"/> I cannot lift or carry anything at all. 	<p>Section 8 – Social Life</p> <ul style="list-style-type: none"> <input type="checkbox"/> My social life is normal and does not increase my pain. <input type="checkbox"/> My social life is normal, but it increases my level of pain. <input type="checkbox"/> Pain prevents me from participating in more energetic activities (IE sports, dancing) <input type="checkbox"/> Pain prevents me from going out very often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have hardly any social life because of my pain.
<p>Section 4 – Walking</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain does not prevent me from walking any distance <input type="checkbox"/> Pain prevents me from walking more than a mile. <input type="checkbox"/> Pain prevents me from walking more than ½ mile. <input type="checkbox"/> Pain prevents me from walking more than ¼ mile. <input type="checkbox"/> I can walk only with crutches or a cane. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet. 	<p>Section 9 – Traveling</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can travel anywhere without increased pain. <input type="checkbox"/> I can travel anywhere, but it increases my pain. <input type="checkbox"/> My pain restricts my travel over 2 hours. <input type="checkbox"/> My pain restricts my travel over 1 hour. <input type="checkbox"/> My Pain restricts my travel to short necessary journeys under ½ hour. <input type="checkbox"/> My pain prevents all travel except for visits to the physician/therapist or hospital.
<p>Section 5 – Sitting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can sit in any chair as long as I like. <input type="checkbox"/> I can sit in my favorite chair for as long as I like. <input type="checkbox"/> Pain prevents me from sitting for more than 1 hour. <input type="checkbox"/> Pain prevents me from sitting for more than ½ hour. <input type="checkbox"/> Pain prevents me from sitting for more than 10 minutes. <input type="checkbox"/> Pain prevents me from sitting at all. 	<p>Section 10 – Employment/Homemaking</p> <ul style="list-style-type: none"> <input type="checkbox"/> My normal homemaking/job activities do not cause pain. <input type="checkbox"/> My normal homemaking/job activities increase my pain, but I can still perform all that is required of me. <input type="checkbox"/> I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (IE lifting, vacuuming) <input type="checkbox"/> Pain prevents me from doing anything but light duties <input type="checkbox"/> Pain prevents me from doing even light duties <input type="checkbox"/> Pain prevents me from performing any job or homemaking chores

Score: _____ out of 50. _____% dysfunction