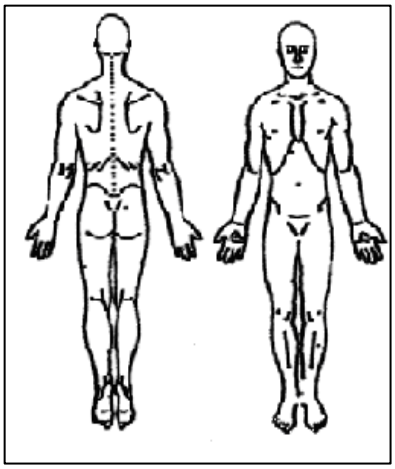
Patient Summary Form

Name: _____ Date: _____

Circle where you have pain or other symptoms:



Briefly describe your pain/symptoms:_____

How/When did your symptoms start? _____

Surgery Date: _____ Reason for Surgery: _____

Average pain intensity: last 24 hours: no pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

Past week: no pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

How often do you experience your symptoms?

① Constantly (76%-100%of the time) ② Frequently (51%-75%of the time)

③ Occasionally (26%-50%of the time) ④ Intermittently (0%-25%of the time)

How often have your symptoms interfered with your usual daily activities?
(include work outside the home and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

How is your condition changing, since care began at *this facility?*

①NA – First Visit ②Much Worse ③ Worse ④A little worse ⑤No change ⑥Better ⑦ Much better

In general, would you say your overall health right now is…

①Excellent ②Very good ③Good ④Fair ⑤Poor

If accident related, please answer the following:

Type of Accident: MVA Slip and Fall Work Related Other: _____

Date of Accident: _____ Time of Day: _____ AM/PM

Location of Accident: _____

City or Town in which accident took place: _____ State: _____

Describe in Detail how the accident occurred: _____

_____

Were you rendered unconscious as a result of the accident? YES NO

Were you taken to a hospital after the accident? YES NO

If yes, by private vehicle or ambulance? _____

If no, how much time had elapsed before you went to the hospital or doctor? _____

Which hospital were you taken to? _____

Have you lost any days from work as a result of the accident? YES NO

Do you have any information concerning the party held responsible for the accident?
YES NO

Have you been contacted by an insurance company from the other party regarding this claim?
YES NO

Are you currently represented by an attorney? YES NO

If yes, Attorney Name and Number? _____

If no, do you wish to retain an attorney? YES NO

_____ _____

Patient Signature Date

Rehab Management Physical Therapy
Medical History/Social Questionnaire

Patient Name: _____ D/O/B_____

Do you now or have you ever had any of the following? (Check all that apply)

_____ Diabetes	_____ Arthritis	_____ High Blood Pressure
_____ Heart Disease	_____ Heart Attack	_____ Pacemaker / Surgical Implant
_____ Vascular Disease	_____ Headaches	_____ Kidney Problems
_____ Open Wounds	_____ Current Infections	_____ Allergies
_____ Hernia	_____ Seizures	_____ Metal In Body
_____ Cancer / Tumor	_____ Thyroid Problems	_____ CVA / Stroke
_____ Previous Fractures	_____ Osteoporosis	_____ Depression
_____ Anxiety	_____ Substance Abuse	_____ Previous Surgeries
_____ Asthma	_____ Presently Pregnant	_____ Hepatitis (A, B, C)
_____ Hypersensitivity to Heat / Cold		_____ Other (_____)

Explanation & approximate date: _____

_____

_____

Are you presently taking medications? Yes / No
If yes, list medications & specify condition _____

_____

Do you currently have transportation to and from Physical Therapy? Yes / No

Do you currently have financial difficulties that would prohibit you from coming to Physical Therapy? Yes / No

Are you currently – please circle one of the following:

Employed Unemployed Retired-Date_____ Disabled-Date_____

Are you currently receiving, or in the last 30 days, have you received Home Health (HH) services from anyone for any type of procedure? Yes / No

***Please notify front desk if you have received or are receiving Home Health.**

If yes, please write Agency name, Phone number and doctor's name who ordered Home Health.

Agency Name:_____Phone:_____

Ordering Physician: _____Date HH began:_____

****

_____ _____
Patient / Guardian Signature Date

R05/11

Patient Name:_____ Date:_____

American Physical Therapy Association

OPTIMAL INSTRUMENT
Demographic Information

1. Date of Birth _____
   mm / dd / yyyy

2. Sex
   1) ____Male
   2) ____Female

3. Race
   1) ____Aleut/Eskimo
   2) ____American Indian
   3) ____Asian/Pacific Islander
   4) ____Black
   5) ____White
   6) ____Other

4. Ethnicity
   1) ____Hispanic or Latino
   2) ____Not Hispanic or Latino

5. Insurance (Please check all that apply)
   1) ____Workers' compensation
   2) ____Self-pay
   3) ____HMO/PPO/private insurance
   4) ____Medicare
   5) ____Medicaid
   6) ____Auto
   7) ____Other

6. Education (Please check one)
   1) ____Less than high school
   2) ____Some high school
   3) ____High school graduate
   4) ____Attended or graduated from technical school
   5) ____Attended college, did not graduate
   6) ____College graduate
   7) ____Completed graduate school/advanced degree

7. Please check the combined annual income of everyone in your house:
   1) ____Less than $10,000
   2) ____$10,000–$14,999
   3) ____$15,000–$24,999
   4) ____$25,000–$34,999
   5) ____$35,000–$49,999
   6) ____$50,000–$74,999
   7) ____$75,000–$99,999
   8) ____$100,000–$149,999
   9) ____$150,000 or more

8. Employment/Work (Check all that apply)
   1) ____Working full-time outside of home
   2) ____Working part-time outside of home
   3) ____Working full-time from home
   4) ____Working part-time from home
   5) ____Working with modification in job because of current illness/injury
   6) ____Not working because of current illness/injury
   7) ____Homemaker
   8) ____Student
   9) ____Retired
   10) ____Unemployed

   Occupation:_____

9. Do you use a: (Check all that apply)
   1) ____Cane?
   2) ____Walker, rolling walker, or rollator?
   3) ____Manual wheelchair?
   4) ____Motorized wheelchair?
   5) ____Other:_____

10. With whom do you live? (Check all that apply)
   1) ____Alone
   2) ____Spouse/significant other
   3) ____Child/children
   4) ____Other relative(s)
   5) ____Group setting
   6) ____Personal care attendant
   7) ____Other:_____

11. Where do you live?
   1) ____Private home
   2) ____Private apartment
   3) ____Rented room
   4) ____Board and care/assisted living/group home
   5) ____Homeless (with or without shelter)
   6) ____Long-term care facility (nursing home)
   7) ____Hospice
   8) ____Other

Adapted/revised in July 2005, August 2006, and December 2012 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther*. 2005;85:515–530.

Patient Name:_____ Date:_____

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1. 12 2. 8 3. 13*)

1.____ 2.____ 3.____

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs* without any difficulty, you would choose: Primary goal. *12*)

Primary goal. ____

Patient Name:_____ Date:_____

Confidence–Baseline

Instructions: Please circle the level of confidence you have for doing each activity today.	**Fully confident in my ability to perform**	**Very confident**	**Moderate confidence**	**Some confidence**	**Not confident in my ability to perform**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

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Rehab Management Physical Therapy
FINANCIAL POLICY

Regarding Insurance & Payment Policy
We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We must emphasize that as physical therapy providers, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. It is our policy to call and verify benefits and eligibility in order for us to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed, at which time there may a balance due on your account. In the event that this occurs we will mail you a statement and appreciate your prompt payment. We will accept the contracted rate & take the necessary adjustments if we are a participating provider with your insurance. Payment for service is due prior to or upon completion of each treatment visit. We accept cash, checks, Mastercard, Visa & American Express. Once your complete insurance information is on file, we will be happy to submit your claims to your insurance company.

Non-covered Expenses
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment of charges denied due to an insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance company does not cover due to limitations of the policy or what they consider reasonable and necessary. It is your responsibility to know what the policy limits are. Our goal is to improve your condition successfully based on what the doctor and the physical therapist deem reasonable and necessary treatment, not on what your policy limits are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses.

Consent and Acknowledgement of Receipt of Privacy Notice (HIPAA)
I understand that as part of the provision of healthcare services, **Rehab Management Physical Therapy** creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations, be restricted. I also understand that the practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Consent to Treat, Assignment of Benefits & Release of Information
The undersigned consents to be (have minor) treated by Rehab Management on an outpatient basis, which includes services rendered under the general and specific instructions of patient's physician or surgeon. The undersigned hereby assigns to Rehab Management all payments for services rendered to patient. The undersigned understands and accepts responsibility for any amount not covered by insurance, except in workers' compensation claims. I hereby authorize Rehab Management to furnish any and all information concerning my (minor's) treatment or illnesses to my (minor's) insurance carriers, attorney or other health professionals. I further authorize any holder of medical or other information about me (minor) pertaining to my (minor's) treatment or diagnosis to release it to Rehab Management.

_____ _____
Patient Signature (Parent or Guardian Signature if Minor) Date

_____ _____
Printed Patient Name Date

_____ _____
Witness Signature Date