Pioneer Spine and Sports Physicians

PHYSICAL THERAPY – PATIENT INFORMATION

Name: _____ Male ___Female ___ Today's Date: _____

Date of Birth: _____ Age: ____ M.D. Name: _____ Next M.D. Visit _____

Please check current work status: Full ___ Restricted Duty __ Unable to Work ____ N/A _____

Type of Work/Occupation: _____

Injury Date and Cause: _____

Primary Complaint: _____

Previous Injuries To This Area: _____

Previous or Current Treatment/Surgeries For This Problem: _____

Diagnostic Tests: _____

Have you fallen in the past year? ___ No ____ Yes. If you answered Yes, how many times?_____

PAST MEDICAL HISTORY (please check either Yes or No next to each item)

Yes	No		Yes	No	
____	_____	Heart Disease/Irregular Heartbeat	_____	_____	Cancer
____	_____	Circulatory Problems	_____	_____	Diabetes
____	_____	High Blood Pressure	_____	_____	Gynecological Problems
____	_____	Lung Disease	_____	_____	Osteoporosis
____	_____	Kidney/Gallbladder Problems	_____	_____	Fractures
____	_____	Liver/Jaundice/Hepatitis	_____	_____	Headaches
____	_____	Gastrointestinal/Ulcers	_____	_____	Visual Problems
____	_____	Bowel/Bladder	_____	_____	Anemia
____	_____	Thyroid	_____	_____	Immune System Suppression
____	_____	Neurological (i.e. Stroke, Seizure)	_____	_____	Metal Implants
____	_____	Automobile Accidents	_____	_____	Arthritis
____	_____	Females: Any Chance of Pregnancy?			

Medications: _____

Allergies to Medications: _____

Patient Signature: _____ Date: _____

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Is sleep disturbed? Yes_____ No _____ Please explain _____

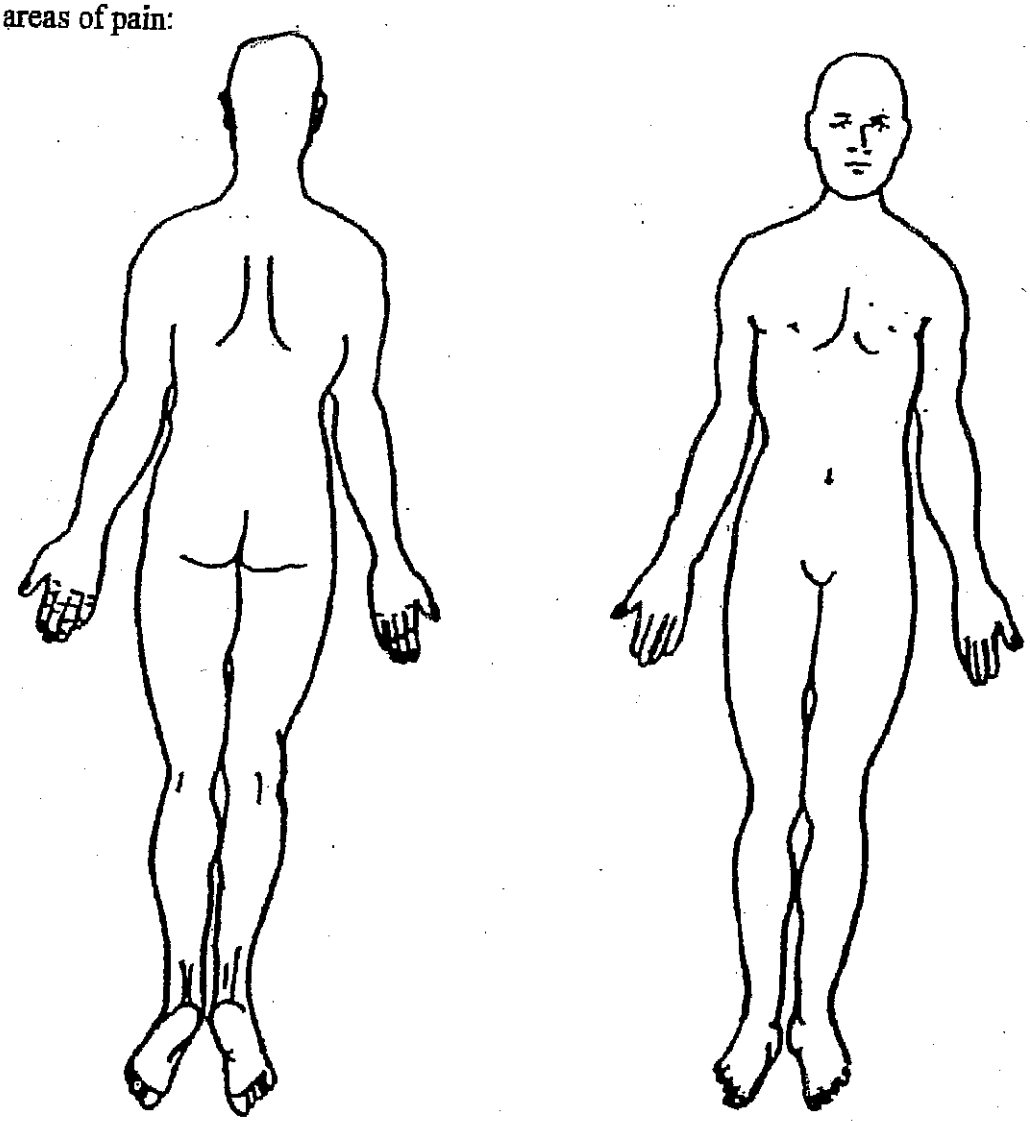
Do you have numbness / tingling / burning? Yes_____ No _____ Where? _____

What brings on pain? _____ What eases pain? _____

Is pain: Constant _____ Off and On _____ Weakness? Yes _____ No _____ Where? _____

Pain Scale: Please circle pain at lowest: 0 1 2 3 4 5 6 7 8 9 10 (emergency)
pain at highest: 0 1 2 3 4 5 6 7 8 9 10 (emergency)

Please shade areas of pain:



Your goals for PT: _____

_____

Patient Signature: _____ Date: _____

Phone number: _____

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. 13 2. 8 3. 14*)

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. *13*)

Primary goal: ____

OUTPATIENT SCHEDULING INFORMATION SHEET

- After your initial visit, you will receive a schedule of appointments.
- It is your responsibility to participate and attend all scheduled appointments.
- If you are unable to attend an appointment you **MUST** notify PSSP Physical Therapy at (413) 785 - 5777. We urge you to call at least **24 HOURS** prior to your scheduled appointment if you would like to cancel. The secretary will either reschedule or confirm your next appointment.
- If you are more than 15 minutes late for your appointment, the attending therapist reserves the right to cancel your appointment if he/she deems necessary.
- If you miss an appointment and do not cancel the appointment ahead of time, this will be considered a **"no-show"**. You will be subject to a $20.00 missed appointment fee.
- If you **"no-show"** for two appointments, you will be discharged.
- If you **cancel** for a total of four appointments, you will be discharged.
- When you are discharged under the above conditions, the following will be notified in writing:
  Your physician
  Your insurance company
  Your attorney
  Your workman's compensation carrier
  All other parties involved.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES. I UNDERSTAND THAT THE PURPOSE OF REGULAR ATTENDANCE WILL ALLOW ME TO GAIN MAXIMUM BENEFIT FROM THERAPEUTIC INTERVENTION.

PATIENT SIGNATURE: _____ DATE: _____

DETACH THIS FOR YOUR RECORDS

ATTENTION PATIENTS

Many insurance companies require that referrals and authorizations be in place prior to treatment being rendered.

It is the responsibility of the patient to call their primary care physician for any referrals, or to call their insurance company with any prior notification that is required. If the referral is not in place at the same time of your visit, you will be asked to sign a waiver if treatment is rendered.

If your insurance requires authorization after your initial evaluation, you will not be scheduled for any follow-up appointments until we have received authorization for your future visits.

If you have any questions, please feel free to call Pioneer Spine and Sports Physical Therapy Department.

Thank you,

Pioneer Spine and Sports Physicians