ADMISSION RECORD

FORM COMPLETION INSTRUCTIONS:

- Please answer all questions (**Please enter N/A if not applicable**)
- All information will remain strictly confidential
- Questions, please ask our office associate

Patient Name:			*Patient Date of Birth*	*Social Security Number*
Mailing Address (No. & Street, Apt., etc.)			*E-Mail Address*	
City	*State*	*Zip Code*	*Gender:* *Female* *Male*	
Home Phone Number ( )	*Work Phone Number* ( )		*Cell Phone Number* ( )	
Your Employer's Name			*Your Employer's Address*	
Primary Insurance Carrier			*Is Insurance Through Your Employer* *If Not, Is It Through* □ *Parent* □ *Spouse* □ *Other*	
Parent's/Spouse's Employer Name				
Is There a Secondary Insurance, If Yes What Is The Name of the Secondary Insurance			*Who Is The Secondary Insurance Through*	
			Emergency Contact and Phone	
Marital Status: □ *Single* □ *Married* □ *Divorced* □ *Widowed*			*Your occupation:*	
Spouses Name:			*Spouses Date of Birth*	*Social Security Number*
PRIMARY CARE Physician Name			*Phone Number*	*Date of Next Office Visit*
REFERRING Physician Name			*Phone Number*	*Date of Next Office Visit*
I was referred to OCPT by:				

PATIENT AUTHORIZATION AND RESPONSIBILITY

I hereby consent to treatment at Ortho Care Physical Therapy, Inc. By consenting to treatment I authorize, on behalf of any covered family member or myself, direct billing of my insurance company and direct payment to Ortho Care Physical Therapy, Inc. By consenting to treatment, I also consent to the release of necessary medical information needed for the processing of the insurance claims, including release to any entity for the continuation of my medical care. I understand that a photocopy of the release is as valid as the original. In the event that my insurance company does not pay or partially pays on behalf of any covered family member or myself, I understand that it is my financial responsibility to remit payment in full to Ortho Care Physical Therapy, Inc. upon completion of the treatment session or within 10 days thereafter. I further understand that if the matter is referred to an attorney or collection agency, I will be responsible to pay actual attorney or collection agency fees and court costs.

Signature of Patient, Guardian/Parent	***Date***

Pain Level Chart

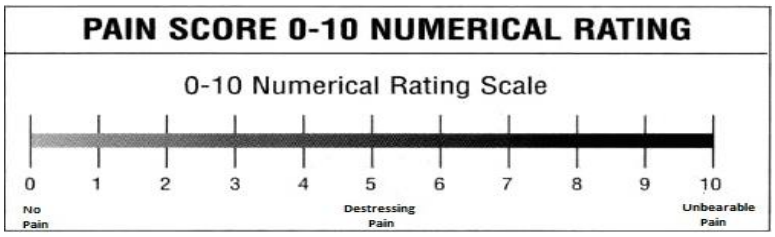
PATIENT NAME: _____

Describe Your Pain: Use this chart to help you describe your particular level of pain to your health care provider.

My pain is:

- ☐ Throbbing
- ☐ Stabbing
- ☐ Dull
- ☐ Aching
- ☐ Other (Please describe) _____
- ☐ Pinching
- ☐ Burning
- ☐ Steady
- ☐ Localized
- ☐ Persistent
- ☐ Comes & Goes

Use the scale below to better estimate the level of the pain you are experiencing: Remember that pain effects everyone differently and only you know what you are feeling. The following scale can help you define the intensity of your pain and describe your discomfort to caregivers so they can provide the best treatment.



0-1: Very little or barely noticeable pain.

2-3: Pain is present, but you may have to stop and think about it to really tell if it is there or gone. You seem just fairly comfortable.

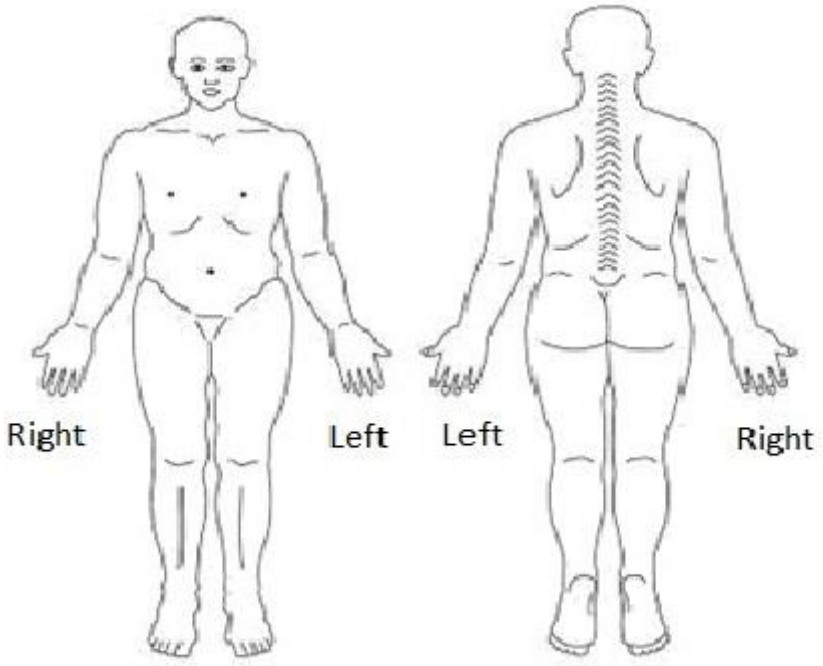
4-5: You now notice your pain, perhaps at rest or during activity. It may interfere with you activities. Level "4" is the level at which it is a good idea to start introducing some avenues of relief.

6-7: Your pain is distracting you, but you may be able to focus on something else rather than the pain for a short period of time. You may be "gritting your teeth" to carry out activities.

8-9: Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it at all. It is difficult to think of anything else but your pain at this level. You may be uncomfortable even during rest or quiet times.

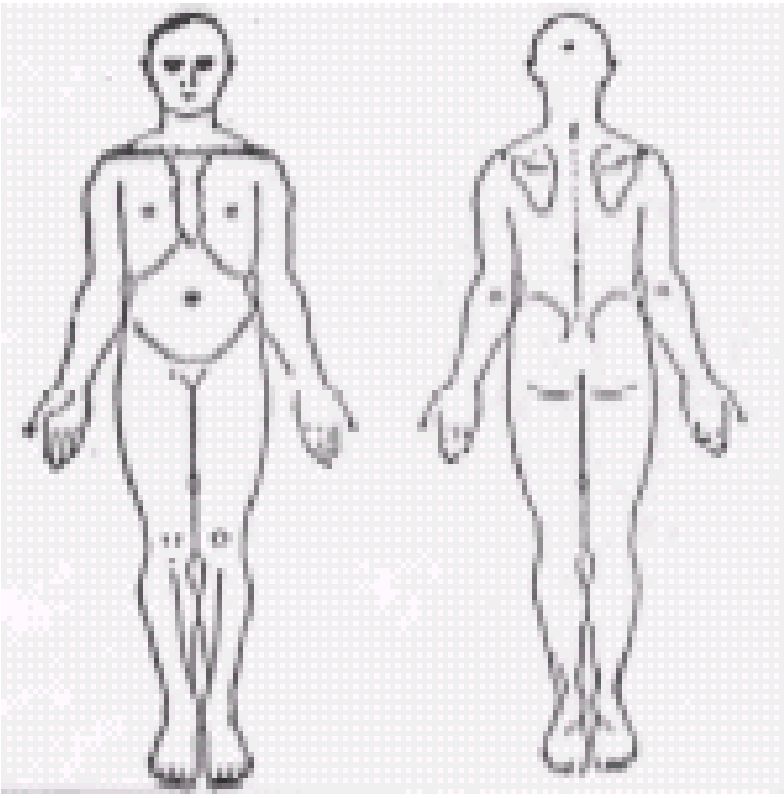
10: Your pain is now the worst you can imagine. Do not wait for "Level 10" before you discuss options with your health care provider.

Please shade areas where you are experiencing pain.



ORTHO CARE Physical Therapy OCPT

PATIENT MEDICAL HISTORY INFORMATION



1. Using the body chart place, place an "x" on the area of your pain and/or symptoms.

2. Please circle the number that represents your pain level. 0 is no pain and 10 is severe pain.

Manageable
0 1 2 3
Moderate
4 5
Moderate/Severe
6 7 8
Severe
9 10

3. Is your injury related to work, a motor vehicle accident, a recreational accident, or other? (Please circle appropriate answer)

4. What was the specific cause of injury, or the series of events leading up to your visit today?

Description: _____

_____

Onset of injury date? _____**Sudden** or **Gradual** (Please circle appropriate answer)

5. Describe how your symptoms progress through the day. (For example better, worse, stiff, same)

_____

6. Do you wake up during the night because of pain? ☐ Yes ☐ No How many times? _____

7. Is there any particular activity that aggravates you symptoms? _____

8. What relieves your symptoms? _____

9. Since your symptoms first started have they: (circle one) increased, decreased, or stayed the same?

10. Since your symptoms first began do you have any difficulty with or control of bladder and/or bowel function? ☐ Yes ☐ No Describe _____

11. List medications you are taking now. _____

_____

12. Please list and date any recent diagnostic tests relating to this injury (CT scan, MRI, Xray, Bone Density Scan, EMG, Cardiac Stress Test, Other) _____

ORTHO CARE Physical Therapy OCPT

PATIENT MEDICAL HISTORY INFORMATION

13. Please list surgeries you have had. Please give procedure and dates, if possible.

_____

_____

14. Do you exercise, and if so what do you do? _____

15. How often do you exercise? **None, Occasionally, 1-2 days/wk, 3-4 days/wk, 5 or more days/wk** (Please circle appropriate answer)

16. How would you rate your general health? **Excellent, Good, Average, Fair, Poor** (Please circle appropriate answer)

17. Do you have any metal including teeth in your body? (i.e. pins, plates, pacemaker) ☐ Yes ☐ No

18. Have you ever had physical therapy and/or Chiropractic treatments before? ☐ Yes ☐ No

If yes, please indicate which, where, when, and for what problems. _____

_____

_____

19. List any allergies you have _____

20. Have you ever had the following?

High blood pressure?	☐ Yes ☐ No	Seizures?	☐ Yes ☐ No
Heart/circulation disorders?	☐ Yes ☐ No	Dizzy Spells?	☐ Yes ☐ No
Arthritis/Osteoarthritis?	☐ Yes ☐ No	Diabetes?	☐ Yes ☐ No
Immune deficiency disease?	☐ Yes ☐ No	Cancer?	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Broken Bones?	☐ Yes ☐ No

21. Have you had any recent trouble with vision? ☐ Yes ☐ No

22. Have you had any recent trouble with hearing? ☐ Yes ☐ No

23. Have you had any unusual weight gain or loss lately? ☐ Yes ☐ No

24. Do you smoke? ☐ Yes ☐ No

If yes, how many Packs/Day _____

25. Do you have an infectious disease? (ie, hepatitis, TB, HIV, shingles, etc.) ☐ Yes ☐ No

26. Have you ever taken steroids or anti-coagulants for an extended period of time? ☐ Yes ☐ No

27. For Women, are you pregnant? ☐ Yes ☐ No

28. Date of your last doctor's appointment? _____

29. Has anyone in your immediate family (parents, brothers, sisters) ever had any of the following?

☐ Cancer, ☐ High Blood Pressure, ☐ Physiological problems, ☐ Stroke, ☐ High Cholesterol, ☐ Diabetes, ☐ Arthritis, ☐ Heart Disease, ☐ Osteoporosis, ☐ Other (explain) _____

_____

Name of person completing this form (print)	Signature of Patient or Responsible Adult and Date

OCPT Cancellation and No Show Policy

Your physician has recommended physical therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments. Your therapist will advise you at your evaluation how many times a week it will be necessary for you to attend.

ALL appointments missed should be made up within the remaining time of current prescription. 3 consecutive NO SHOWS WILL RESULT IN IMMEDIATE DISCHARGE due to non-compliance and your referring physician will be notified.

Ortho Care Physical Therapy requires 24 hour notice for any cancellation. If you fail to give 24 hour advance notice for any cancellation or you do not show for your scheduled appointment an administrative fee of $25 may be applied to your account.

I, _____, have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

_____

Print Patient Name

_____ _____

Patient Signature Date

ORTHO CARE PHYSICAL THERAPY, INC.

Receipt of Notice of Privacy Practices Written Acknowledgement

I, _____, have received a copy of the Ortho Care Physical Therapy Inc. Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Privacy Policy Available on Website

Revised 11/12/2014