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 ( )	
Primary Insurance Carrier Name			Secondary Insurance Carrier Name	
Insured's relationship to you □ Self □ Parent □ Spouse □ Other			Insured's Name (Who carries insurance contract)	
Insured's Employer Name:			Insured's Employer Address:	
City	State	Zip	Employer Phone Number:	
Insured's Date Of Birth:			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 as well as, Telehealth and/or Evisits. 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 for collection, I will be responsible for the attorney's fees and court costs.

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

PATIENT MEDICAL HISTORY INFORMATION

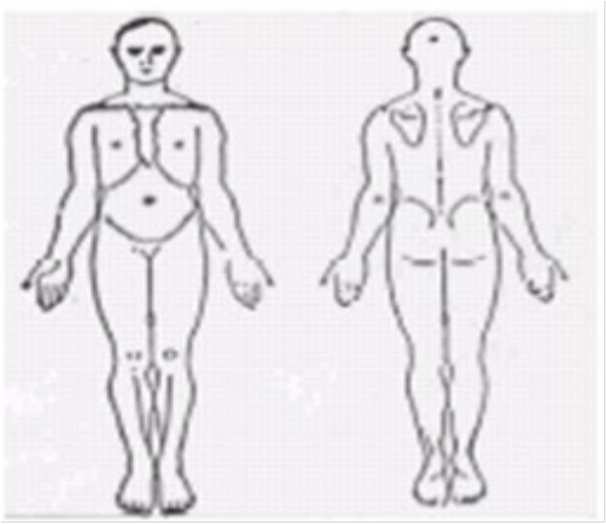
To ensure you receive a complete and thorough evaluation, please provide us with important background information on the following form. All information is considered confidential and will be released only to your physician unless prior written authorization is given. Thank you.

Name: _____

What are you coming in for? _____

When did your symptoms start? _____

Body Chart: Please mark your present symptoms on the body chart.



Since Onset of Symptoms:
(Please Circle)

Same/Better/Worse

Localized/Referred/ Sudden/ Gradual

Pain/ Numbness/ Tingling

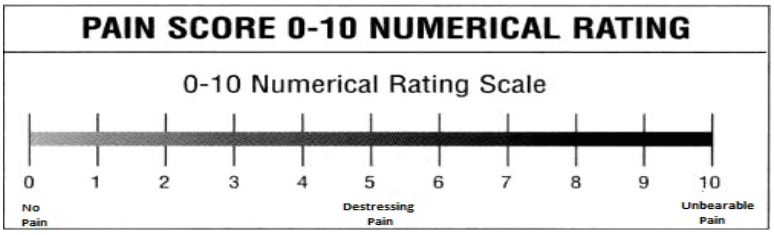
What makes it feel better? _____
_____

What makes it feel worse? _____
_____

Describe Your Pain: Use this chart to help you describe the type of pain to your health care provider.
My pain is:

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

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.



ORTHO CARE Physical Therapy OCPT

PATIENT MEDICAL HISTORY INFORMATION

Are you seeing or receiving any of the following for your current condition? (Check Box)

- ☐ Physician (MD, DO)
- ☐ Psychiatrist/psychologist
- ☐ Dentist
- ☐ Physical Therapist/Occupational Therapist
- ☐ Attorney
- ☐ Chiropractor
- ☐ Acupuncture
- ☐ Injections
- ☐ Other

Testing Performed for this problem: (Check box)

- ☐ Xray
- ☐ Bone Scan
- ☐ CT Scan
- ☐ MRI
- ☐ EMG
- ☐ Other _____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections and/or skin patches): _____

_____

Which of the following OVER THE COUNTER medications have you taken in the past week? Check box

- ☐ Aspirin
- ☐ Tylenol
- ☐ Decongestants
- ☐ Laxatives
- ☐ Antacids
- ☐ Antihistamines
- ☐ Vitamins/Supplements
- ☐ Advil/Motrin/Ibuprofen
- ☐ Other _____

Have you EVER been diagnosed as having any of the following conditions?

- ☐ Cancer, If yes describe what kind: _____

☐ Allergies	☐ DVT	☐ Liver Disease/Hepatitis	☐ Sexually Transmitted Disease
☐ Anemia	☐ Eye Problems/Vision Loss	☐ Lung Disease	☐ Shortness of Breath
☐ Anxiety	☐ Fatigue/Weakness	☐ Metal in Body/Implants	☐ Skin Condition
☐ Arthritic conditions	☐ Fibromyalgia	☐ Neurological (MS, Parkinson's)	☐ Stomach/ GI Condition
☐ Asthma	☐ Headaches	☐ Neuropathy	☐ Stroke
☐ Chemical dependency (alcoholism)	☐ Hearing Loss	☐ Osteoarthritis	☐ Thyroid problems
☐ Chronic Cough	☐ Heart Attack/Disease/CHF	☐ Osteoporosis	☐ Tuberculosis
☐ Circulation problems	☐ High Blood Pressure	☐ Pacemaker	☐ Ulcers
☐ Coronavirus (COVID-19)	☐ HIV/AIDS	☐ Pregnant	☐ Vascular Conditions
☐ Depression	☐ Infections (Recent)	☐ Prostate Problems	☐ Weight Gain/Loss (Recent)
☐ Diabetes	☐ Kidney Disease/Stones	☐ Rheumatoid Arthritis	☐ Other:
☐ Dizziness/Light Headed	☐ Latex Allergy	☐ Sensitive to Hot/Cold	

Please list any surgeries or other conditions for which you have been hospitalized within the past few years, including the approximate date of the surgery or hospitalization:

Date	Surgery/hospitalization
_____	_____
_____	_____
_____	_____

PATIENT MEDICAL HISTORY INFORMATION

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) within the past few years and the approximate date of injury:

Date	Injury
_____	_____
_____	_____
_____	_____

Currently Living with:
☐ Alone ☐ Parents ☐ Siblings ☐ Spouse ☐ Children ☐ Significant Other
☐ Regular Housekeeper (times/wk ____)

Type of Dwelling:
☐ House ☐ 1 floor ☐ 2 floors ☐ Apartment ☐ Condo ☐ Stairs to enter

Laundry: ☐ First Floor ☐ Second Floor ☐ Basement

Additional Information:

1. Occupation _____
2. Have you fallen within the past 12 months? Yes No
3. During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes No
4. How much coffee or caffeine-containing beverages do you drink in a day? _____
5. How many packs of cigarettes do you smoke a day? _____
6. If one drink equals one beer or glass of wine, how much alcohol do you drink in a week_____
7. How are you able to sleep at night? ☐ Fine ☐ Moderate difficulty ☐ Only with medication
8. How often do you exercise? ☐ None ☐ Occasionally ☐ 1-2 days/wk ☐ 3-4 days/wk ☐ 5 or more days/wk
9. What exercises do you normally perform? ☐ Cycling ☐ Running ☐ Weight Training ☐ Walking ☐ Other____
10. What are your goals for therapy? _____

How did you hear about Ortho Care Physical Therapy?

☐ Physician	☐ Facebook	☐ Drive-by
☐ Yellow Pages	☐ Website	
☐ Family Friend	☐ Newspaper	

Therapist Use:

Form reviewed with patient? Yes _____ No _____

Date _____ Therapist Signature _____

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

Name: _____ Date: _____

Patient-Specific Functional Scale

Please identify at least three important activities that you are unable to do or have difficulty doing as a result of your current problem. Write these down. Then rate your ability to do the activities in the last week by circling the appropriate number.

Activity 1: _____

unable to perform 0 1 2 3 4 5 6 7 8 9 10 able to perform at pre-injury level

Activity 2: _____

unable to perform 0 1 2 3 4 5 6 7 8 9 10 able to perform at pre-injury level

Activity 3: _____

unable to perform 0 1 2 3 4 5 6 7 8 9 10 able to perform at pre-injury level

Activity 4: _____

unable to perform 0 1 2 3 4 5 6 7 8 9 10 able to perform at pre-injury level

Activity 5: _____

unable to perform 0 1 2 3 4 5 6 7 8 9 10 able to perform at pre-injury level

SCORE: Sum of individual #s divided by the total # of activities: ☐

Patient-Specific Function Scale	% Patient Does	G Code
10	100%	0% impaired
9	90%	1-19% impaired
7-8	70-80%	20-39% impaired
5-6	50-60%	40-59% impaired
3-4	30-40%	60-79% impaired
1-2	10-20%	80-99% impaired
0	0%	100% impaired

Stratford P, Gill C, Westaway M, Binkley J. Assessing disability and change on individual patients: a report of a patient-specific measure. Physio Can. 1995; 47: 258-263.