Orion Physical Therapy Specialists, LLC

NEW RETURN PHONE-IN WALK-IN APPT DATE/TIME PT ICD9's_____

Patient Information

Patient Name	Nickname	Birthdate	Social Security #	Home Phone
Address	Cell Phone	Marital Status S M D W Legally Sep	Gender	Drivers License #
	Referring Physician	Seeking therapy for	Date & Type of Surgery / Injury	
Occupation	Patient's Employer & Work Address			Employer's Phone
Primary Care Physician	Emergency Contact's Name		Contact's #	Relationship to Patient
Email address			**If injury is due to auto/other accident, please ask receptionist for a PI form**	
Date of Injury, if applicable	If a work-related injury, employer name at time of injury		Case Manager/Claims Adjustor Name & Phone	

Insurance Information

Primary Insurance Name	Policy #,WC or Auto Claim #	Group Number	Policyholder's Birthdate	Relationship to Patient
PolicyHolder's Name (if other than patient)	PolicyHolder's Home Address			Policyholder's Phone
PolicyHolder's Employer, work address and phone (if PH is other than patient)			Policyholder's SSN	Copay Amount, if known
Secondary Insurance Name	Policy Number	Group Number	Policyholder's Birthdate	Relationship to Patient
PolicyHolder's Name (if other than patient)	PolicyHolder's Home Address			Policyholder's Phone
PolicyHolder's Employer, work address and phone (if PH is other than patient)			Policyholder's SSN	Copay Amount, if known
Tertiary Insurance Name	Policy Number	Group Number	Policyholder's Birthdate	Relationship to Patient
PolicyHolder's Name (if other than patient)	PolicyHolder's Home Address			Policyholder's Phone
PolicyHolder's Employer, work address and phone (if PH is other than patient)			Policyholder's SSN	Copay Amount, if known

Other Pertinent Information

Have you had any Physical or Speech Therapy this year? Yes No If so, how many visits of PT & ST combined? _____

Have you had any Occupational Therapy this year? Yes No If so, how many visits? _____

Are you receiving Home Health Services of any kind at this time? **Yes** No ***If yes, please inform receptionist at this time.***

Have you received any type of Home Health Services? **Yes** No If so when were you discharged (your final visit)?_____

Regarding Privacy: I have read a copy of Orion Physical Therapy Privacy Policies (sign & date) _____

Please initial the following that are acceptable to you: Orion staff may leave messages with a person at my home _____ , and/or on my voicemail/answering machine at home _____ , work _____ or cell phone ____. OPTS can discuss my account or care with the following individual _____.

I give my consent for treatment, authorize the release of necessary information to insurance carriers & appropriate personnel, & request that my insurance carriers pay OPTS directly. If direct payment is not permitted, I request that payment be issued jointly to Orion Physical Therapy Spec. & myself and mailed directly to OPTS. I will endorse checks so OPTS may cash & apply to my account accordingly. I understand I am financially responsible for any and all charges incurred. In the event my account is referred to a debt collector, I understand I will be responsible for all costs incurred to collect the debt in addition to my account balance.

Patient/Guardian Signature_____ Date _____

Patient Questionnaire/ History

Name: _____ Date of Birth: ____/____/_____ Right_____ or Left _____ handed

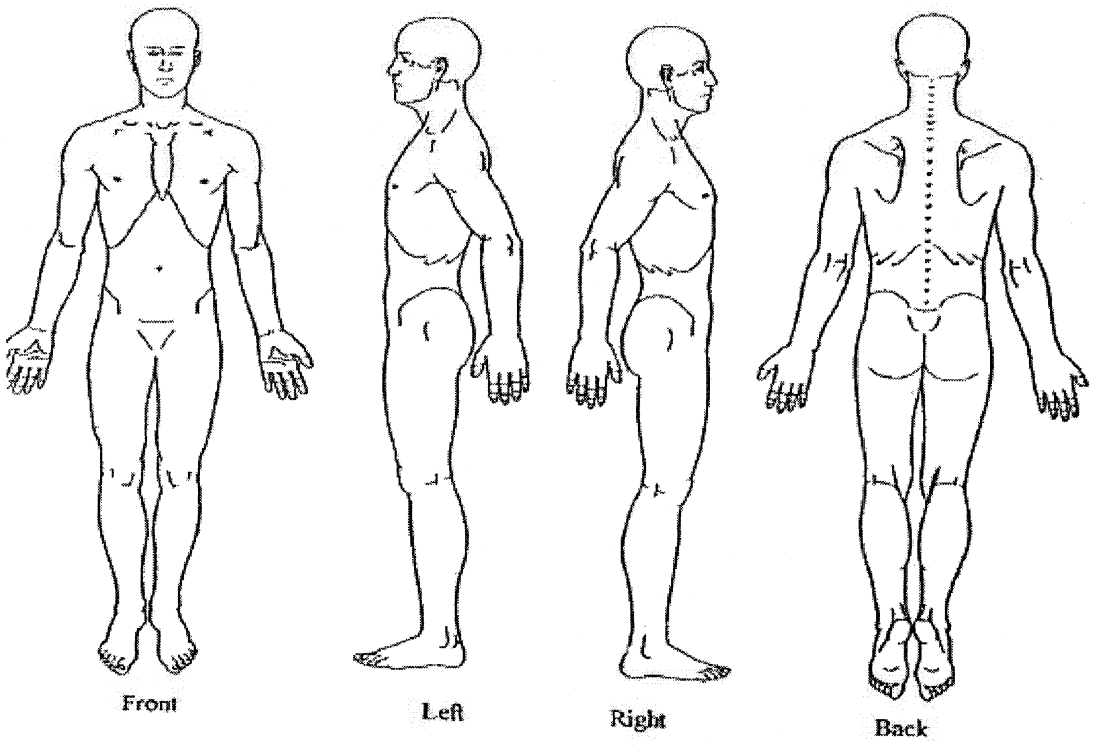
What is your Chief Complaint?_____

_____

Rate your chief complaint in order of severity from worst (5) to least (1):

Pain_____ Decreased Motion_____ Swelling/Edema_____ Stiffness_____ Loss of Function_____

Where is your problem? Indicate on the body chart below. Pain: xxx Numbness: ooo Tingling: zzz



Indicate the nature of your pain and symptoms: ____Sharp ____Dull ____Piercing ____Shooting ____Aching

____Deep ____Superficial ____ Tingling ____Numbness ____Intermittent ____Burning ____Stabbing

What is the frequency of your symptoms? ____Constant ____Daily ____x/day ____Weekly ____x/Week

When and how did this problem begin?_____

_____

What makes your symptoms/pain worse?_____

_____

What makes your symptoms/ pain better? _____

_____

Rate your pain on a visual scale (0-10) with 0=no pain and 10=excruciating pain:

Worst it has been_____ Past 2 to 4 weeks_____ Past 24 hours_____ At this moment_____

Are your symptoms worse in the: _____Morning _____Afternoon _____Evening _____ Inconsistent

Are your symptoms better in the: _____Morning _____Afternoon _____Evening _____ Inconsistent

Are your symptoms: _____Improving _____Worse _____Stable

What does your pain feel like?

Please use the words listed below to describe the pain you have experienced during the past two weeks. Circle ONLY the words that best describe your pain. Leave out any category that is not suitable. Use ONLY the single word in each category that BEST applies.

1	2	3	4	5
Flickering	Jumping	Pricking	Sharp	Pinching
Quivering	Flashing	Boring	Cutting	Pressing
Pulsing	Shooting	Drilling	Lacerating	Gnawing
Throbbing		Stabbing		Cramping
Beating		Lancinating		Crushing
6	**7**	**8**	**9**	**10**
Tugging	Hot	Tingling	Dull	Tender
Pulling	Burning	Itchy	Sore	Taut
Wrenching	Scalding	Smarting	Hurting	Rasping
	Searing	Stinging	Aching	Splitting
			Heavy	
11	**12**	**13**	**14**	**15**
Tiring	Sickening	Fearful	Punishing	Wretched
Exhausting	Suffocating	Frightful	Grueling	Blinding
		Terrifying	Cruel	
			Vicious	
			Killing	
16	**17**	**18**	**19**	**20**
Annoying	Spreading	Tight	Cool	Nagging
Troublesome	Radiating	Numb	Cold	Nauseating
Miserable	Penetrating	Drawing	Freezing	Agonizing
Intense	Piercing	Squeezing		Dreadful
Unbearable		Tearing		Torturing

*Modified from The McGill-Melzack Pain Questionnaire

Medical History

Has this problem affected your daily life or routine? Briefly describe.

_____

_____

Have you had previous similar episodes of this current problem? ____Yes ____ No

If yes, were you treated with; (circle disciplines, which apply)

Physical Therapy Acupuncture, M.D. (Meds, TPI's) Massage Therapist Chiropractor Pilates
General Exercise Exercise with Trainer Self medicated (Advil) Ignored it Other

Did they help to alleviate your symptoms? ___Yes ___No. Briefly Explain. _____

_____ _____

Have you undergone any medical tests for this condition? ____Yes ____No (X-rays, MRI's, CT scans, EMGs) If yes, do you know the results?_____

Any other illness, past injuries we should be aware of?_____

Past surgeries___Yes ___No. If Yes, give brief details:_____

List the medications you are currently taking (over the counter/prescription):_____

_____

_____

Please answer the following questions:	Yes	No
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold? Do you have any allergies?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Do you use any assistive devise? (cane foot orthotics)		
12) Do you have a history of neck or back problems?		
13) Have you noticed any shortness of breath or decrease in exercise tolerance?		
14) Have you ever been Diagnosed with any of the following:		
Emphysema		
Thyroid Problems		
Rheumatoid Arthritis		
Other Arthritis		
Hepatitis		
Kidney Disease		
Prostate Disease		
Tuberculosis		
Anemia		
Asthma		
Multiple Sclerosis		
Chemical Dependency (alcohol)		
Chemical Dependency (drugs)		
Depression		
High blood pressure		
Cardiac problems		
Stroke		
Diabetes		
Cancer of any sort		
Osteoporosis? Date of your last bone scan:		

Social History

Do you work outside of the home? ____Yes ____No. If Yes, what is your occupation?_____

_____

Are you presently working? _____Yes, _____No, since:_____

Are the physical/emotional demands of your present occupation (Circle one) high moderate minimal ?

Please explain_____

_____

Overall activity level: ____Sedentary ____Light ____Moderate ____Heavy ____Very heavy

Sports and Exercise (Type, Frequency, Duration) _____

_____

Use of Tobacco? ____Yes ____No. Use of Alcohol? ____Yes ____No.

Who can we thank for this referral? _____