Physical Therapy New Patient Paperwork: Page 1 of 5

Patient Name: _____

Date of Birth: _____

Chart ID #: _____

PHYSICAL INFORMATION—Today's visit is for (check all that apply):

[ ] Pre/Post Surgical DOS:_____ [ ] Headaches
[ ] Multiple Sclerosis [ ] Other

APPROXIMATE DATE OF ONSET:
What were you able to do before that you cannot do now? _____

_____

What are your personal goals for physical therapy? _____

_____

Have you been treated by another physical therapist for this before? Yes No
If yes, Name of facility _____

MEDICAL HISTORY INFORMATION
Any know allergies? [ ] Yes [ ] No If yes, please list: _____

Currently taking any prescription medication? [ ] Yes [ ] No If yes, pleas list or provide copy:
_____

Please list orthopedic surgeries: _____

Do you have a history of (check all that apply):

[ ] Arthritis [ ] Cancer [ ] Diabetes [ ] Heart/pulmonary problem [ ] Other
[ ] Osteoporosis [ ] Urinary incontinence (leakage)

Are you or could you be pregnant? [ ] Yes [ ] No

Do you have a pacemaker, neurostimulator, heart valves, surgical clips, artificial joints or limbs or other metal objects in you body? [ ] Yes [ ] No (If yes please circle to indicate)

Do you have an Advanced Directive? [ ] Yes [ ] No (If yes please provide a copy to this facility for placement in your medical record.

Patient Signature:_____Date:_____

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PAIN SCALE

INSTRUCTIONS: Write the number that describes the pain you are currently experiencing based on the 0-10+ rating scale. Remember, the numbers refer to your pain, not how strong or weak you feel. For example: Rating #1 is Very Weak Pain and Rating #7 is very Strong Pain.

10+	Maximal
10	Very, very strong
9	
8	
7	Very strong
6	
5	Strong
4	Somewhat strong
3	Moderate
2	Weak
1	Very weak
0.5	Very, very weak
0	No pain at all

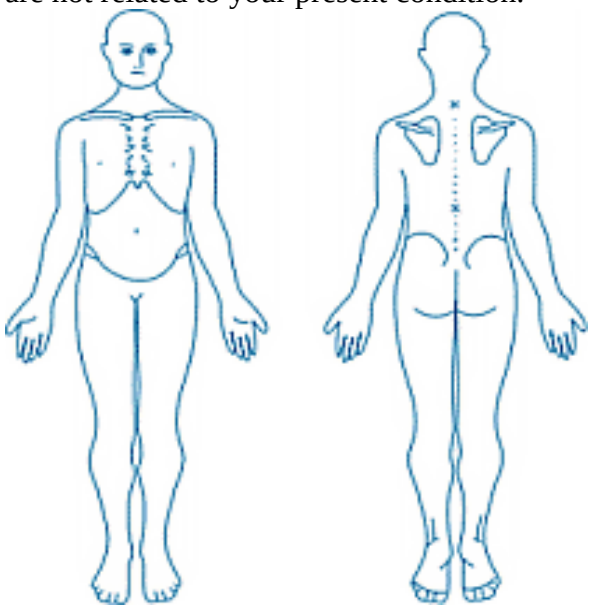
Your pain rating right now _____

Best you have felt in last 30 days _____

Worst you have felt in last 30 days _____

PAIN DRAWING

INSTRUCTIONS: 1. Circle where your pain, if any, is located. 2. Use the symbols below to describe your pain or add your own written comments. Please, do not indicate areas of pain which are not related to your present condition.



Key	
///	Stabbing
XXX	Burning
OOO	Pins and Needles
===	Numbness

Patient Signature:_____Date:_____

Physical Therapy New Patient Paperwork: Page 3 of 5

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FUNCTIONAL STATUS SCALE (INSTRUCTIONS: For each of the following activities, please circle the appropriate number using the rating scale below.)

1	Can perform without difficulty
2	Can peform with difficulty or assistance (walking aid, help with stairs)
3	Can perform, but painful
4	Cannot currently perform due to my current medical condition
N/A	I do not normaly perform this activity

Sitting over 15 minutes	1	2	3	4	N/A
Sit to /from stand	1	2	3	4	N/A
Standing over 15 minutes	1	2	3	4	N/A
Driving	1	2	3	4	N/A
Walking on even surfaces	1	2	3	4	N/A
Walking on uneven surfaces	1	2	3	4	N/A
Balance	1	2	3	4	N/A
Sleeping	1	2	3	4	N/A
Rolling over	1	2	3	4	N/A
Transferring to/from bath or shower	1	2	3	4	N/A
Transferring to/from car	1	2	3	4	N/A
Going up/down stairs	1	2	3	4	N/A
Accessing buildings/opening doors	1	2	3	4	N/A
Dressing/Grooming	1	2	3	4	N/A
Preparing/serving food	1	2	3	4	N/A
Using the phone	1	2	3	4	N/A
Managing Children	1	2	3	4	N/A
Shopping	1	2	3	4	N/A
Lifting more than 10 pounds	1	2	3	4	N/A
Carrying more than 10 pounds	1	2	3	4	N/A
Reaching	1	2	3	4	N/A
Stooping/squatting	1	2	3	4	N/A
Bathing/showering	1	2	3	4	N/A

Patient Signature:_____ Date:_____

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INFORMED CONSENT FOR TREATMENT:

Physical therapy evaluation and treatment involves certain inherent risks. Patients are asked to exert effort and perform activities and exercises with increasing degrees of difficulty. These risks may include, but are not limited to cardiovascular, muscle, ligament, joint or disc injury. Symptomatic aggravation of your current condition is also possible. Risk factors have been reduced to the best of our ability, however, any increase in your current level of discomfort, or any other change in your symptoms should be immediately reported to a staff member.

In accordance with the APTA Guidelines, information provided to the patient shall include the following:

- A clear description of the treatment ordered or recommended
- Material (decisional) risks associated with the proposed treatment
- Expected benefits of treatment
- Comparison of the benefits and risks possible with and without treatment
- Reasonable alternatives to the recommended treatment

If you have any questions on the above, please feel free to ask your therapist.

The above items have been discussed with me to my satisfaction and I understand and consent to the planned physical therapy treatment.

_____ _____

Signature of Patient/Guarantor Date Signature of Witness Date

RELEASE OF INFORMATION AUTHORIZATION:

I authorize Rowe Neurology Institute, and/or its assigns, to release information from my medical record to my referring and/or primary care physician, my insurance carrier, my attorney and/or employer. The purpose for such disclosure is to provide information and to coordinate medical care.

By law, my records cannot be disclosed without my written consent. I further understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. This consent expires automatically one year from the date signed below, or sooner if revoked by written demand.

_____ _____

Signature of Patient/Guarantor Date Signature of Witness Date

Patient Name: _____

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Missed Appointment Policy:

It is very important to return to each of your scheduled appointments on time. Each physical therapy visit is allotted one hour for treatment. If you are unable to attend an appointment, call our office to cancel or re-schedule at least one business day in advance between 8:00am and 5:00 p.m., Monday through Friday. Failure to cancel in advance or failure to attend an appointment without proper notification of an emergency will result in a $50.00 charge to cover the expense.

_____ _____

Signature of Patient/Guarantor Date Signature of Witness Date