SportsCare Physical & Aquatic Therapy

Medical/Physical History form

BACK/LOWER EXTREMITIES

Patient Name:_____ **Diagnosis:** _____ **Date:** _____

Age _____ **Height:** _____**inches** **Weight:** _____**lbs.**

Name of your doctor: _____ **Type of doctor:** : _____

Date of Injury: _____. **Date of Surgery:**_____ .

History of present illness/injury/pain:_____.

Primary Concern: (***Why am I here for physical therapy):***

Check all that apply:

1. Base level of function: □ **walking** □ **negotiating obstacles** □ **moving around** □ **standing** □ **stairs** **Lifting**
(<u>was</u> able to do) □ **running** □ **hopping** □ **squatting** □ **sleep** □ **shopping** □ **house keeping** □ **cooking**

2. Functional limitation(s): □ **walking** □ **negotiating obstacles** □ **moving around** □ **standing** □ **stairs** **Lifting**
(<u>can't</u> do) □ **running** □ **hopping** □ **squatting** □ **sleep** □ **shopping** □ **house keeping** □ **cooking**

Pain scale: ***(0 is best, 10 is worst)*****>>>** **worst:** **current:** **at best:**

Pain description: **Pain Behavior in 24 hour cycle:** **Pain frequency:**

Aggravating factors:

Better with:

General Health: Good

Previous history of similar symptoms: **How many episodes?** **The year of 1st episode?** _____

History of falls: **how many?**

Medical History: **No known significant Medical History**

□ Heart disease	□ Stroke	□ Joint replacement	□ Strain
□ Diabetes Type I	□ High blood pressure	□ Fibromyalgia	□ Sprain
□ Diabetes Type II	□ Obesity	□ Osteoarthritis	□ Bone fracture
□ Fainting spells	□ Pacemaker	□ Rheumatoid arthritis	□ Tendonitis
□ Lupus	□ Parkinson	□ Muscular dystrophy	□ Bursitis
□ Alzheimer's/Dementia	□ Traumatic brain injury	□ Cancer	□ Spinal surgeries
□ Hepatitis	□ Seizures	□ Shortness of breath	□ Allergies: _____

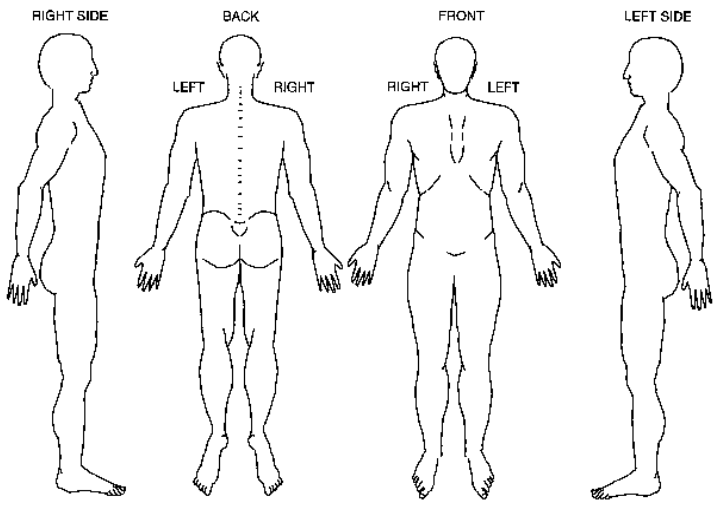
Diagnostic Testing/Imaging: □ **MRI** □ **CT scan** □ **X ray Findings**:

_____

What are your goal(s) in physical therapy?

_____

Identify the area(s) of your concern by moving your cursor over the site(s) of your symptoms and checking them off (X) >>>



OFFICIAL USE ONLY:

Total Score: ____ **pts.;** ____ **%**

Total Score: ____ **pts.;** ____ **%**

Patient's Name: _____ Date: _____

The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, *do you* or *would you* have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
2	Your usual hobbies, re creational or sporting activities.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
3	Getting into or out of the bath.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
4	Walking between rooms.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
5	Putting on your shoes or socks.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
6	Squatting.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
7	Lifting an object, like a bag of groceries from the floor.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
8	Performing light activities around your home.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
9	Performing heavy activities around your home.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
10	Getting into or out of a car.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
11	Walking 2 blocks.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
12	Walking a mile.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
13	Going up or down 10 stairs (about 1 flight of stairs).	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
14	Standing for 1 hour.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
15	Sitting for 1 hour.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
16	Running on even ground.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
17	Running on uneven ground.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
18	Making sharp turns while running fast.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
19	Hopping.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
20	Rolling over in bed.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/ 80 (fill in the blank with the sum of your responses)**

_____

SportsCare Physical Therapy, PC (516) 420-1927

SportsCare Physical Therapy, PC
814 Fulton Street
Farmingdale, NY 11735

MY MEDICATION RECORD

List prescriptions, over-the-counter drugs, vitamins and herbal medicines.

Patient name: _____ Date: _____

Allergies: _____

Pharmacy name: _____ Phone: (____) _____

Primary doctor name: _____ Phone: (____) _____

Medication name/dose:	Medication treats (condition):	Medication frequency:	Notes/ questions:
		Off	
		Off	
		Off	
		Off	
		Off	
		Off	
		Off	
		Off	

17131

PT/OT Patient Intake Form
(version 1.5)
www.palladianhealth.com/members

Palladian

Last name		First name	

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

O Neck	O Shoulder	O Hip	O Stroke rehabilitation	**Other (also indicate region)**
O Upper/ mid-back	O Elbow	O Knee	O Spinal cord rehabilitation	O Post-surgical
O Lower back	O Wrist	O Ankle	O Neurologic rehabilitation	O Fracture
	O Hand	O Foot	O Balance/coordination	O Other

2. When did this problem first begin?

O Less than 1 month ago O 1-3 months ago O 4-6 months ago O 7-12 months ago O More than 1 year ago

	Has this problem...	No	Yes
3.	... resulted from a work injury (i.e. workers' compensation insurance claim)?	O	O
4.	... resulted from a motor vehicle accident (i.e. no fault insurance claim)?	O	O
5.	... recently been evaluated by a medical doctor?	O	O
	Since this problem began, have you noticed...	**No**	**Yes**
6.	... so much weakness in both your arms that you are unable to lift them?	O	O
7.	... so much weakness in both your legs that you are unable to walk without help?	O	O
8.	... difficulty controlling your bowel or bladder, or have you been unable to urinate?	O	O
9.	... pain in your chest, shortness of breath, or coughing up blood?	O	O
10.	... that one leg felt more warm, more swollen, more red, or more tender than the other?	O	O
	Have you recently...	**No**	**Yes**
11.	... had blurred vision, double vision, dizziness, or fainting?	O	O
12.	... had any type of infection, fever, or chills?	O	O
13.	... had any type of surgery, surgical procedure, or medical procedure?	O	O
14.	... lost a lot of weight without really trying to (i.e without being on a diet)?	O	O
15.	... had any type of accident, fall, or trauma?	O	O
	Have you ever...	**No**	**Yes**
16.	... been diagnosed with cancer?	O	O
17.	... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?	O	O
18.	... been diagnosed with a weakened immune system?	O	O
19.	... used any injected drugs (i.e. non-prescription drugs)?	O	O
20.	... used steroids such as prednisone for more than 4 weeks?	O	O
	Is this problem something that ...	**No**	**Yes**
21.	... you've had before?	O	O
22.	... generally gets worse (i.e more severe or frequent) with movement, activity, or exercise?	O	O
23.	... generally gets better (i.e. less severe or frequent) with rest?	O	O
24.	... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?	O	O
25.	... is also being treated by a health professional other than a physical or occupational therapist?	O	O

47602

PT/OT Patient Outcomes Form
(version 1.5)
www.palladianhealth.com/members

Palladian

Last Name		First name	

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is	O	O	O	O	O

The following questions are about activities you might do during a typical day.
Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	O	O	O
3. Climbing several flights of stairs	O	O	O

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
4. Accomplished less than you would like	O	O	O	O	O
5. Were limited in the kind of work or other activities	O	O	O	O	O

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6. Accomplished less than you would like	O	O	O	O	O
7. Did work or other activities less carefully than usual	O	O	O	O	O

	Not at all	A little bit	Moderately	Quite a bit	Extremely
8. During the <u>past week</u>, how much did pain interfere with your normal work (including work outside the home and housework)?	O	O	O	O	O

These questions are about how you feel and how things have been with you during the past week.
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the <u>past week</u>...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	O	O	O	O	O
10. Did you have a lot of energy?	O	O	O	O	O
11. Have you felt downhearted and depressed?	O	O	O	O	O

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
12. During the <u>past week</u>, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	O	O	O	O	O

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now		O	O	O	O	O	O	O	O	O	O	O	
14. On average		O	O	O	O	O	O	O	O	O	O	O	
15. At its best		O	O	O	O	O	O	O	O	O	O	O	
16. At its worst		O	O	O	O	O	O	O	O	O	O	O	

PT/OT Treatment Form
(version 1.5)
www.palladianhealth.com/providers

Palladian

4287

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Specialty: O PT O OT
Location: O Office O Facility

Provider ID: 1700895646

Section A. Provider information

First name
Last name
Facility name: SportsCare Physical Therapy

Service Street Address: 814 Fulton Street, Suite B
Farmingdale, NY 11735

Check if
O Workers' compensation injury O No-fault injury

Section B. Patient information

First name
Last name
Health plan
Member ID

Date of (M M – D D – Y Y Y Y)
Birth
Onset
Last visit
Requested start

Section C. Primary region of complaint (select only 1 region)

Spine
O Cervical
O C/S+radiculopathy
O Thoracic
O Lumbosacral
O L/S+radiculopathy

Upper extremity
Shoulder O L O R
Elbow O L O R
Wrist O L O R
Hand O L O R

Lower extremity
Hip O L O R
Knee O L O R
Ankle O L O R
Foot O L O R

Other (also indicate region)
O Post-surgical
O Fracture
O Other

Rehabilitation
O Stroke
O Spinal cord
O Neurological
O Balance/coordination

Primary ICD-9 [.]

Section D. Red flags (i.e. signs or symptoms that may indicate potentially serious pathology)

Does this patient have any red flags (e.g. "yes" answers to PT/OT Patient Intake Form questions 6-20)? O No O Yes
Does this patient have any contraindications to receiving PT/OT care from you for this complaint? O No O Yes

Section E. Evaluation

Based on information provided by the patient, your examination, and your treatment history with this patient (if any), what is your evaluation of this patient's primary region of complaint? Please choose one box for each of these columns.

Symptoms	Physical function	Overall health	Prognosis
O Very mild	O Very good	O Very good	O Very good
O Mild	O Good	O Good	O Good
O Moderate	O Moderate	O Moderate	O Moderate
O Severe	O Poor	O Poor	O Poor
O Very severe	O Very poor	O Very poor	O Very poor

Section F. Management plan (i.e. how you plan on managing this patient's complaint)

Education about:	O Diagnosis	O Prognosis	O Remaining active	O Other	O None
Home/self-care:	O Heat/ice	O General exercise	O Specific exercises	O Other	O None
Supervised exercise:	O Strengthening	O Stretching	O Stabilization	O Other	O None
Modalities:	O Heat/ice	O TENS/EMS	O Ultrasound	O Other	O None
Manual therapy:	O Manipulation	O Mobilization	O Soft tissue	O Other	O None

Number of PT/OT visits used since last PT/OT Treatment Form was submitted:
O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 O Other

Phone 516 - 420 - 1927 Fax 516 - 420 - 1952

Provider signature: X Date (/ /) MM / DD / Y Y Y Y

4287

V:PalladianPTOTtreatment(1.5)20100113

Note: By completing and signing this form below, the provider indicates that they:
1. provided/supervised all PT/OT services, and 2. are a participating PT/OT provider, and 3. provided all PT/OT services in a credentialed practice.

SportsCare Physical Therapy, PC

Date of call_____ **Appt. date/time**_____

Name_____**Date of Birth**_____**SS#**_____

Address_____**City**_____**St** **Zip**_____

Home Phone_____ **Cell Phone** _____**Work Phone** _____

Spouse_____ **Email address**_____

If Child, Parents Names_____

Employer Name/Address_____**Occupation**_____

Emergency contact_____**Phone #** _____ **Relationship to patient** _____

Referring MD **Name** _____**Town**_____

Primary Care **Name** _____ **Town**_____

Which body part are you going to be treated for? _____

Was this the result of a car accident or work related injury?_ Yes No Date of accident _____

Did you have previous physical therapy this year? Yes No If yes, how many visits_____

How did you hear about us? Family/Friend name: _____

What is your primary insurance?

Other : _____

Name_____Address_____ Phone_____

ID# _____Grp# _____ Subscriber_____DOB:_____

Subscriber SS#_____ Relationship to patient_____

What is your secondary insurance?

Other: _____

Name_____Address_____ Phone_____

ID# _____Grp# _____ Subscriber_____DOB:_____

Subscriber SS#_____ Relationship to patient_____

IF WORKERS COMP/NO FAULT INSURANCE, PLEASE FILL IN:

Name_____

Address_____Phone_____Fax_____

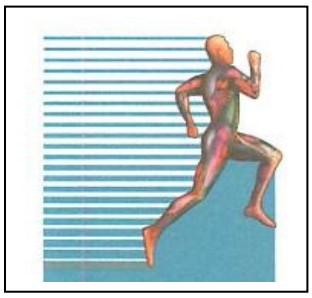
WCB#_____Carrier Case #_____File/Claim#_____

Policy #_____Policy Holder_____Claim Rep_____

Employer at time of accident_____

I authorize SportsCare Physical Therapy, PC to release any information to my insurance company that is necessary to expedite the payment of my claims. I understand that I am responsible for all charges not covered by my insurance including co-payments, co-insurance and deductibles. I understand that if my account is placed in collection, I am responsible for any and all fees associated with being placed into collection and legal proceedings. I also understand that it is my responsibility to obtain all necessary referrals and prescriptions when appropriate and that if said referrals are not obtained, I am responsible for the charges not covered under the referral. I authorize benefits to be paid to SportsCare Physical Therapy, PC. I authorize SportsCare Physical Therapy, PC to contact the insurance commissioner on my behalf. In the event that my workers compensation or no fault claim is denied, I will make arrangements with SportsCare Physical Therapy, PC to be paid by my private insurance and/or myself.

Patient Signature (or Signature of Parent or Guardian)_____Date_____



SportsCare Physical Therapy, PC
814 Fulton Street
Farmingdale, NY 11735
516-420-1927/516-420-1952
www.sportscareptpc.com

RELEASE OF INFORMATION

I give consent to SportsCare Physical Therapy, PC to disclose or request all or any part of the patient's medical record to any person or entity which is or may be liable under a contract to the facility, family member or employer of the patient for all or part of the facilities charge, including, but not limited to physical therapy services, insurance companies, workers compensation/no fault carriers, welfare funds or the patient's employer or any New York State or Federal agency per current rules and regulations. SportsCare Physical Therapy, PC has the authority to reject any unreasonable request by an office or institution if such request might violate the patient's right to privacy. I understand that confidentiality of my medical records are protected under state and federal law and that this release gives the consent to SportsCare Physical Therapy, PC only and not to any party to whom such information is released.

Patient/Responsible Party initials: _____

ASSIGNMENT OF BENEFITS

I hereby assign and set forth SportsCare Physical Therapy, PC sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of care and treatment rendered to me or my dependent. I request that payment of authorized insurance benefits be made on my behalf directly to SportsCare Physical Therapy, PC.

Patient/Responsible Party initials: _____

CONSENT TO TREAT

I hereby request and consent to SportsCare Physical Therapy, PC to perform physical therapy treatment as prescribed by my physician and/or recommended by my physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy treatment may have some risk. I understand that I have the right to ask about these risks and have any questions answered about my condition and treatment at any time during the course of my care. I authorize the physical therapist to provide any additional care or treatment, which is deemed necessary, should during the course of treatment such action be warranted. I understand that following an initial evaluation and appropriate re-evaluations, a description of my condition/diagnosis, presenting signs and symptoms, contraindications and precautions to treatment and expected benefits of treatment will be explained to me. I have read and understand this consent and authorize SportsCare Physical Therapy, PC (including physical therapist assistants and physical therapy students in training) to administer treatment under the direction and supervision of the physical therapist.

Patient/Responsible Party initials: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SportsCare Physical Therapy, PC is committed to preserving the privacy of your personal health information. We have available a detailed notice of privacy practices which explain your rights and our obligations under the law. I acknowledge on this date that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

Patient/Responsible Party initials: _____

We value your time and as such, appointment times are at a premium. To get the best results from your treatment, it is imperative that you attend PT consistently. **If you cancel, please do so 24 hours in advance.** This will allow another patient to obtain that spot and receive their treatment. You may be subject to calling for available appointments (we will not pre book appointments) if you "No Show" (miss without calling) 3 visits. No Showing for appointments prevents someone else from receiving treatment and leaves us with an empty time in our work day. In addition, your insurance company may inquire about your attendance which may affect their determination in approving and paying for continued treatment. **Cancellations made within 24 hours of your appointment and "No Shows" will be charged a $25.00 fee.** This is neither billable nor payable by your insurance company and will be your responsibility.

Copayments are due upon arrival and prior to treatment. We accept cash, checks and credit cards (Visa, MC, Discover).

_____ _____/_____/_____
Patient/Responsible party signature Date

_____ _____/_____/_____
SCPT team member signature Date