Ventura Orthopedics

Therapy Services

Rehabilitation Screening
Confidential Medical History

Patient's Name: _____ Today's Date: _____

Nickname: _____ Patient's Age: _____

Please complete the following questions to the best of your ability. This will help us to develop a treatment with you that meet your individual needs.

1. What are we seeing you for today? _____

2. Date of injury or when problem last caused you to seek medical attention: _____

3. How did your current problem begin? ☐ Lifting ☐ Twisting ☐ Falling ☐ Car Accident ☐ Unknown

   ☐ Other: _____

4. Were you hospitalized for this problem? ☐ Yes ☐ No

   If yes, please give dates: _____

5. Are you currently being seen by any of the following? ☐ Dentist ☐ Chiropractor ☐ Osteopath

   ☐ Physical Therapist ☐ Occupational Therapist ☐ Psychiatrist / Psychologist

   If you are seeing any of the above, please describe the reason: _____

   _____

6. What can you no longer do because of your current illness or accident? _____

   _____

7. Please mark the areas where you have seen a ***decline in your abilities since your most recent illness***:

   ☐ Getting in or out of bed ☐ Getting in or out of chairs ☐ Walking/Balance
   ☐ Eating ☐ Dressing ☐ Grooming
   ☐ Lifting ☐ Bending ☐ Other: _____

8. Are you experiencing pain due to your current accident or illness? ☐ Yes ☐ No
   Using the following scale, where 0 is no pain and 10 is the most amount of pain, please rate your pain **during rest**: (please circle)

   0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

   Using the same scale, please rate your pain **during activity**: (please circle)

   0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

9. Have you had therapy for this recent illness? ☐ Yes ☐ No

   If yes, please explain where and when, and the outcome of the therapy: _____

   _____

10. Are you presently working? ☐ Yes ☐ No

    Occupation: _____

11. Are you: ☐ Right-Handed ☐ Left-Handed

Please continue on reverse side.

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12. Do you use a : ☐ Cane ☐ Walker ☐ Other: _____ ☐ None

13. What type of exercise are you currently doing? _____

_____

14. How, if at all, have your exercise and daily activities changed due to your recent illness? _____

_____

15. Rate your stress over the past 4 weeks: (please circle)

No Stress 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ High Stress

16. Any recent significant change in your appetite? ☐ Yes ☐ No

17. Do you currently experience any of the following?

☐ Cardiac Problems	☐ Diabetes	☐ Hypertension
☐ Orthopedic Problems	☐ Rheumatoid Arthritis	☐ GI Problems
☐ Cancer	☐ Seizures	☐ Multiple Sclerosis
☐ Fibromyalgia	☐ Depression	☐ Drug / Alcohol Dependency

18. Have you ever had a broken bone or fracture? ☐ Yes ☐ No

If yes, which body part(s): _____ When? _____

19. Do you smoke? ☐ Yes ☐ No

20. Are you pregnant? ☐ Yes ☐ No

21. List any medical allergies: _____

22. List all prescription or over-the-counter medications you are currently taking if you have not currently provided this information already: _____

_____

_____

23. What would you like to learn more about related to your current illness / injury? _____

_____

_____

24. Do you have problems with any of the following?

☐ Caring for Yourself ☐ Obtaining Meals ☐ Keeping Appointments

25. Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Ventura Orthopedics

Therapy Services

Therapy Services FAQ's

(Frequently Asked Questions)

Upon starting your Physical Therapy or Hand Therapy program you may have several questions. We will try to answer many of them below:

1. ***What should I wear?*** For individual comfort and convenience you should wear clothes you would be comfortable exercising in, including appropriate footwear. Sandals heels and other open toed shoes are discouraged. Additionally, consider garments that will allow for the discreet exposure of the area you are having treated.

2. ***Can I bring my children or spouse?*** Due to privacy laws, we encourage only a direct caregiver or parent be present for treatments. Additionally, our facility contains extremely tempting equipment for children to play on. In the interest of safety, we require all non-treating children to remain in the reception area with adult supervision.

3. ***Do I need a towel?*** For your convenience, we have towels at your disposal. However, we do not have a shower facility in all locations. At times your therapy may consist of moderate levels of exertion, and/or application of thermal, electrical and ultrasonic modality. Therefore, we urge all Therapy participants to refrain from application of lotions and perfumes as they may interfere with your treatment program.

4. ***Do you bill my insurance?*** As a courtesy, our reception staff verifies insurance eligibility and benefits prior to undergoing therapy treatment. Many insurance plans have co-pays, co-insurance, and deductibles. We encourage you to check your individual policy and limitations and/or pre-authorization requirements as outlined in your "Eligibility of Benefits" handbook. Patients should check with our receptionists on a weekly basis to evaluate their account. Please notify our office immediately if your insurance plan changes. Failure to do so may result in nonpayment of insurance claims for all therapy charges.

5. ***How long will my therapy sessions last?*** Typically, you can expect each session to last between 45 and 60 minutes. To ensure that your therapy time is maximized, we request cell phones and pagers be turned off prior to your therapy appointment.

6. ***Do I need to make an appointment?*** Yes. Please make appointments at our reception desk 1-2 weeks in advance to ensure a convenient schedule for you. If you must cancel an appointment, kindly give 24 hours notice and every effort will be made to reschedule your visit at a convenient time. If you are insured by Worker's Compensation insurance, we are required to inform your adjustor or nurse case manager of any missed appointments.

7. ***Am I responsible for payment at time of service?*** If you have a co-pay, you will be responsible for payment before services are given. If you have a co-insurance, we will be happy to bill you after we receive notification from your insurance company. If your insurance is out of network with our office, all payment will be due at the time of service.

8. ***Will I be charged for any supplies I receive?*** Money for any supplies must be collected at the time of purchase. You may be able to get reimbursed by your insurance company, but we do not bill supplies to insurance companies. We will be happy to provide you with the necessary paperwork for you to submit to your insurance company. If your insurance is through Workers Compensation, we will not charge you for any supplies you receive.

Continued on back side.

Ventura Orthopedics

Therapy Services

Therapy Services FAQ's

(Frequently Asked Questions)

9. ***Are there consequences for arriving late or missing appointments?*** Please make every effort to arrive on time. Late arrivals put stress on the therapist to meet all their patients' needs. We recognize that some appointments cannot be kept due to unforeseen circumstances. However, we ask for 24 hour notice so that the time can be re-booked for another client. Our policy is to charge $50 for an appointment that is missed without the courtesy of a call, and $25 for appointments that are canceled with less than 24 hours notice. Workers Compensation adjusters will be notified of each offense. At the discretion of the therapist, you may be removed from the schedule if you miss three appointments in a row.

10. ***If I am referred by a physician from Ventura Orthopedics, do I have to receive occupational or physical therapy from Ventura Orthopedics Therapy Services?*** You may seek therapy services from a therapist of your choice who may or may not be employed by Ventura Orthopedics. If you choose to be treated by a therapist employed by Ventura Orthopedics, please be aware that your physician may have a financial interest in Ventura Orthopedics and its therapy service.

EACH PATIENT (OR RESPONSIBLE PARTY) IS FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED. WHILE WE ARE PLEASED TO PREPARE INSURANCE FORMS, THE OBLIGATION FOR PAYMENT OF OUR FEES REMAINS THAT OF THE PATIENT.

FEES FOR ANY PHYSICIAN, MRI, ETC., WILL BE BILLED SEPARATELY FROM YOUR THERAPY FEES.

I have read and understand the above information.

_____	_____	_____
Patient/Parent Signature	Printed Name	Date

Ventura Orthopedics

Therapy Services

Consent for Treatment

I hereby authorize the providers at Ventura Orthopedics to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

_____ _____

Patient's Printed Name Date

_____

Patient or Representative Signature

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Ventura Orthopedics for any services furnished me by the therapists. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ _____

Patient or Representative Signature Date

Insurance Authorization for Assignment of Benefits/Information Release

I, the undersigned, authorize payment of medical benefits to Ventura Orthopedics for any services furnished me by the provider. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient or Representative Signature Date

Ventura Orthopedics

Therapy Services

Oswestry Questionnaire

Patient Name: _____ Date: _____

Section I: To be Completed by Patient

Patient Initials: _____

Number of Days of Back Pain: _____ **(this episode)**

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only one line which most closely describes your current condition.**

Pain Intensity

- ___ The pain is mild and comes and goes.
- ___ The pain is mild and does not vary much.
- ___ The pain is moderate and comes and goes.
- ___ The pain is moderate and does not vary much.
- ___ The pain is severe and comes and goes.
- ___ The pain is severe and does not vary much.

Personal Care (Washing, Dressing, etc.)

- ___ I do not have to change the way I wash and dress myself to avoid pain.
- ___ I do not normally change the way I wash or dress myself even though it causes some pain.
- ___ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- ___ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- ___ Because of my pain, I am partially unable to wash and dress without help.
- ___ Because of my pain, I am completely unable to wash and dress without help.

Lifting

- ___ I can lift heavy weights without increased pain.
- ___ I can lift heavy weights, but it causes increased pain.
- ___ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g., on a table, etc.)
- ___ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ___ I can only lift very light weights.
- ___ I can not lift or carry anything at all.

Walking

- ___ I have no pain when walking.
- ___ I have pain when walking, but I can still walk my required normal distances.
- ___ Pain prevents me from walking long distances.
- ___ Pain prevents me from walking intermediate distances.
- ___ Pain prevents me from walking even short distances.
- ___ Pain prevents me from walking at all.

Sitting

- ___ Sitting does not cause me any pain.
- ___ I can only sit as long as I like providing that I have my choice of seating surfaces.
- ___ Pain prevents me from sitting for more than one hour.
- ___ Pain prevents me from sitting for more than 1/2 hour.
- ___ Pain prevents me from sitting for more than 10 minutes.
- ___ Pain prevents me from sitting at all.

Please continue completing form on back side.

Standing

- ___ I can stand as long as I want without increased pain.
- ___ I can stand as long as I want, but my pain increases with time.
- ___ Pain prevents me from standing more than 1 hour.
- ___ Pain prevents me from standing for more than 1/2 hour.
- ___ Pain prevents me from standing for more than 10 minutes.
- ___ I avoid standing because it increases my pain right away.

Sleeping

- ___ I get no pain when I am in bed.
- ___ I get pain when I am in bed, but it does not prevent me from sleeping well.
- ___ Because of my pain, my sleep is only 3/4 of my normal amount
- ___ Because of my pain, my sleep is only 1/2 of my normal amount.
- ___ Because of my pain, my sleep is only 1/4 of my normal amount.
- ___ Pain prevents me from sleeping at all.

Social Life

- ___ My social life is normal and does not increase my pain.
- ___ My social life is normal, but it increases my level of pain.
- ___ Pain prevents me from participating in more energetic activities (e.g., sports, dancing, etc.)
- ___ Pain prevents me from going out at all.
- ___ Pain has restricted my social life to my home.
- ___ I have hardly any socail life because of my pain.

Traveling

- ___ I have no pain when traveling.
- ___ I get some pain when traveling, but none of my usual forms of travel make it any worse.
- ___ I get increased pain when traveling, but it does not cause me to seek alternative forms of travel.
- ___ I get increased pain when traveling, which causes me to seek alternative forms of travel.
- ___ My pain restricts all forms of travel, except that which is done while I'm lying down.
- ___ My pain restricts all forms of travel.

Employment/Homemaking

- ___ My normal job/homemaking activities do not cause pain.
- ___ My normal job/homemaking activities increase my pain, but I can still perform all that is required of me.
- ___ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- ___ Pain prevents me from doing anything but light duties.
- ___ Pain prevents me from doing even light duties.
- ___ Pain prevents me from performing any job or homemaking chores.

Section II: To be Completed by Physical Therapist/Provider

SCORE: Initial _____ **%** **Subsequent** _____ **%** **Subsequent** _____ **%** **Discharge**_____ **%**

Date: _____ **Date:** _____ **Date:** _____

Number of Treatment Sessions: _____ **Diagnosis/ICD-9 Code:** _____