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.

Ventura Orthopedics

Therapy Services

Rehabilitation Screening
Confidential Medical History

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

Neck Disability Index Questionnaire

Ventura Orthopedics

Therapy Services

Patient Name: _____ Date: _____

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by marking the **ONE CHOICE** that most applies to you. We realize you may feel that more than one statement may relate to you, but **PLEASE, just circle the one choice which closely describes your problem *right now*.**

SECTION 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 – Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 – Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

Please continue completing form on back side.

SECTION 6 – Concentration

A. ◯ I can concentrate fully when I want to with no difficulty.
B. ◯ I can concentrate fully when I want to with slight difficulty.
C. ◯ I have a fair degree of difficulty in concentrating when I want to.
D. ◯ I have a lot of difficulty in concentrating when I want to.
E. ◯ I have a great deal of difficulty in concentrating when I want to.
F. ◯ I cannot concentrate at all.

SECTION 7 – Work

A. ◯ I can do as much work as I want to.
B. ◯ I can only do my usual work, but no more.
C. ◯ I can do most of my usual work, but no more.
D. ◯ I cannot do my usual work.
E. ◯ I can hardly do any work at all.
F. ◯ I cannot do any work at all.

SECTION 8 – Driving

A. ◯ I can drive my car without neck pain.
B. ◯ I can drive my car as long as I want with slight pain in my neck.
C. ◯ I can drive my car as long as I want with moderate pain in my neck.
D. ◯ I cannot drive my car as long as I want because of moderate pain in my neck.
E. ◯ I can hardly drive my car at all because of severe pain in my neck.
F. ◯ I cannot drive my car at all.

SECTION 9 – Sleeping

A. ◯ I have no trouble sleeping.
B. ◯ My sleep is slightly disturbed (less than 1 hour sleepless).
C. ◯ My sleep is mildly disturbed (1-2 hours sleepless).
D. ◯ My sleep is moderately disturbed (2-3 hours sleepless).
E. ◯ My sleep is greatly disturbed (3-5 hours sleepless).
F. ◯ My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 – Recreation

A. ◯ I am able to engage in all recreational activities with no pain in my neck at all.
B. ◯ I am able to engage in all recreational activities with some pain in my neck.
C. ◯ I am able to engage in most, but not all recreational activities because of pain in my neck.
D. ◯ I am able to engage in a few of my usual recreational activities because of pain in my neck.
E. ◯ I can hardly do any recreational activities because of pain in my neck.
F. ◯ I cannot do any recreational activities at all.