OPTIMAL PERFORMANCE AND PHYSICAL THERAPIES

Patient Information				
First Name:	MI:	Last Name:		
Address:	City:		ST:	Zip:
Cell Phone: ( )	Other Phone: ( )			
Last 4 Digits SS#:	Date of Birth:	Sex: Male / Female	Married / Single / Other	
Employer:	Email:			
Physician Information				
Referring Physician:	Physician Phone:			
Primary Care Physician:	Physician Phone:			
Insurance Information				
Primary Insurance:	ID Number:			
Subscriber's Name (if different):	Date of Birth:	Relationship:		
Subscriber's Address:	City:	ST:	Zip:	
Subscriber's Home Phone: ( )	Other phone: ( )			
Secondary Insurance:	Secondary Insurance ID#:			
Subscriber's Name:	Date of Birth:	Relationship:		
Emergency Contact Information				
Contact Name:	Relationship:			
Primary Phone: ( )	Other Phone: ( )			
Other Information				
Is this work related? Yes / No	If yes, date of injury:			
Is this related to a motor vehicle accident? Yes / No	If yes, date of accident:			
Medicare Patients Only				
Are you <u>currently</u> receiving ANY home health services (including nursing, dressing assistance, bathing assistance, IV antibiotics, injections, respiratory services, physical therapy, occupational therapy, or speech therapy)? Yes / No				
Name of Agency:				
Yes, I would like to receive appointment reminders via Text / Voicemail (Circle one) or No, thanks				
How did you hear about us? ☐ Physician Referral ☐ Family/Friend ☐ Other (describe): _____				

I hereby give consent for treatment for myself, or the named minor child, by the staff at OPPT and/or as directed by my referring physician. I authorize the release of any medical information necessary to process claims for these services. I authorize release of clinical information for treatment, payment, and healthcare operations. I assign medical benefits payable for these services directly to OPPT. I understand that I am responsible for payment at the time of service of any applicable co-payments, co-insurance, deductibles, or any self-pay charges if no insurance company or third party is being billed for treatment received.

Signature: _____ Date: _____

Parent/Legal guardian Signature: _____ Date: _____ Relationship: _____

_____
Initial

I **acknowledge** that I have received a copy of OPPT's Notice of Privacy Practices. I understand that this information describes how OPPT may disclose and use my protected health information.
If I have any questions, I can contact Beth Patterson, PT, DPT, SCS, CHC, Chief Compliance Officer at: 35111 US Highway 19 N, STE 204, Palm Harbor, FL 34684.

Name: _____ **Date:** _____

This form contains a series of questions designed to help your Physical/Occupation Therapist evaluate your condition. This information will help your therapist provide you the best possible care. Please answer each question as accurately and completely as you can.

DOB: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Do you have a pacemaker? Yes No **Do you smoke?** Yes No **Do you live alone?** Yes No

Falls: Have you had two or more falls within the last 12 months? Yes No
Have you had a fall that resulted in an injury within the last 12 months? Yes No

ALLERGIES: (Including any medication(s) you are allergic to): _____
Are you latex sensitive? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

During the past month have you been feeling down, depressed, or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, But not today NO**

Please describe your current health (circle): Excellent Very Good Fair Poor

Have you RECENTLY noted any of the following (check all that apply)?

- ☐ Fatigue
- ☐ Fever/Chills/Sweats
- ☐ Nausea/Vomiting
- ☐ Weight loss/gain
- ☐ Poor Balance/Falls
- ☐ Headaches
- ☐ Swelling in your legs/ankles
- ☐ Any skin changes/rashes
- ☐ Numbness or tingling
- ☐ Unusual muscle weakness
- ☐ Dizziness/lightheadedness
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Specific food intolerances
- ☐ Changes in bowel or bladder function
- ☐ Any type of infection in the past 3 months
- ☐ Constipation
- ☐ Diarrhea
- ☐ Fainting
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Heart Palpitations

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart Attack/Heart Disease
- ☐ High Blood Pressure
- ☐ Chest pain/Angina
- ☐ Heart valve problems
- ☐ Circulation problems
- ☐ Blood clots (DVT)
- ☐ Stroke (TIA or CVA)
- ☐ Anemia
- ☐ Diabetes (Type 1 or 2)
- ☐ Infectious Diseases (HIV, Hepatitis, TB)
- ☐ Depression
- ☐ Lung problems
- ☐ Pneumonia
- ☐ Asthma
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Arthritis
- ☐ Bladder/Urinary Tract Infection
- ☐ Kidney problem/Infection
- ☐ Bone or joint infection
- ☐ Pelvic Inflammatory Disease
- ☐ Chemical dependency (i.e. alcoholism)
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Gout
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Stomach Ulcers
- ☐ Liver problems
- ☐ Endometriosis

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Abdominal Aortic Aneurysm
- ☐ Diabetes (Type 1 or 2)
- ☐ Stroke (TIA or CVA)
- ☐ Depression
- ☐ Tuberculosis
- ☐ Thyroid Problems
- ☐ Blood Clots

Please list any medications you are currently taking (including prescriptions, over the counter, herbals, and vitamin/mineral/dietary supplements).

Medication name	Dosage/Frequency	Condition Medication Taken For	Route of Administration
			Oral / Injection / Other
			Oral / Injection / Other
			Oral / Injection / Other
			Oral / Injection / Other
			Oral / Injection / Other
			Oral / Injection / Other
			Oral / Injection / Other
			Oral / Injection / Other
			Oral / Injection / Other
			Oral / Injection / Other
			Oral / Injection / Other

Have you ever taken steroid medications for any medical condition? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical condition? **YES NO**
Are you currently taking any anti-inflammatory medications (Aleve, Motrin, Aspirin, Ibuprofen, etc.)? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____
2. _____
3. _____
4. _____

Please list Sport and Leisure activities that you participate in:

_____

Please list your occupation, including activities that compromise your workday:

_____

What are your personal goals related to therapy and your recovery?

_____

Current Condition:

Treatment received so far for this problem (Physical Therapy, Massage Therapy, Home Health, Chiropractic, Injections, Heat/Ice, Other) _____

Please list special diagnostic tests performed for this problem (X-ray, MRI, CT Scan, EMG/NCV, Blood Tests, Doppler Study, Bone Scan, Ultrasound, Cardiac Stress Test)

_____

Have you had the same or similar problem in the past? **YES NO** If yes, how was it treated?

_____

How long did it take for you to feel better? _____

If your current symptoms are due to an injury, describe how it occurred?

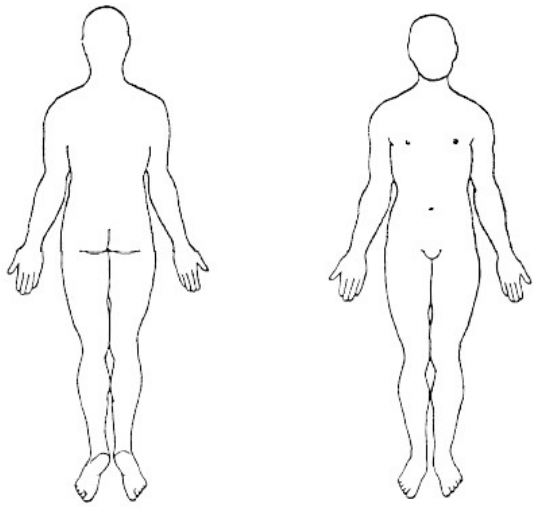
_____

_____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/Sharp pain**
◯ **Dull/Aching pain**
||| **Numbness**
= **Tingling**



Date of onset of current symptoms/injury: _____

How did your current symptoms begin? Gradually Suddenly

Your symptoms are currently: ☐ Getting better ☐ About the same ☐ Getting worse

Your symptoms currently: ☐ Come and go ☐ Are constant ☐ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

When are your symptoms the best? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

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Please circle the number below which best represents your overall average level of function.

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

Using the 0 to 10 scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____