OPTIMAL PERFORMANCE AND PHYSICAL THERAPIES

Patient Information			
First Name:	MI:	Last Name:	
Address:	City:	ST:	Zip:
Cell Phone: ( )	Other Phone: ( )		
Full SS#:	Date of Birth:	Sex: Male / Female	Married / Single / Other
Employer:	Email:		
Physician Information			
Referring Physician:	Physician Phone:		
Primary Care Physician:	Physician Phone:		
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:		
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.

Optimal Performance and Physical Therapies

Job Analysis	
Employee Name:	Employer Name:
Supervisor Name:	Employer Phone: ( )
Job Title:	
Time Shift Begins: __________ Time Shift Ends: __________	Have you worked since injury? YES NO
Last day worked: __________	Job you will be returning to:

Employment Concerns					
Are you motivated to return to work?	YES	NO	Are you concerned about re-injury at work?	YES	NO
Do you want to return to work?	YES	NO	Are you confident that you will be able to return to work?	YES	NO
Are you happy with your job?	YES	NO	Are you concerned that you will not be physically able to do your job?	YES	NO

Please describe how your injury is limiting your ability to work: ____
____
____

Job Demands

Number of Hours

Activity	0	1-3	4-7	7+
Sitting				
Standing				
Walking				
Bending				
Crawling				
Climbing				

Number of Hours

Activity	0	1-3	4-7	7+
Reaching				
Crouching				
Kneeling				
Balancing				
Pushing				
Pulling				

Weight Handled per Hour

Lift and Carry	0	5-10	11-20	21+
Up to 10 lbs				
11 – 25 lbs				
26 – 50 lbs				
51 – 75 lbs				
76 – 100 lbs				

Weight Handled per Hour

Lifting Overhead	0	5-10	11-20	21+
Up to 10 lbs				
11 – 25 lbs				
26 – 50 lbs				
51 – 75 lbs				
76 – 100 lbs				

Please provide below any additional comments/concerns we should be aware of: __________________________
____
____

Preparer's Signature ____ **Todays' Date:** ______________________

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? ____

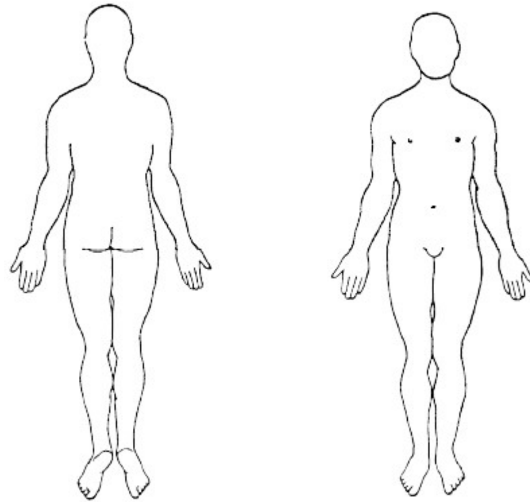
If your current symptoms are due to an injury, describe how it occurred?

____

____

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: __________