Onsite Therapy Solutions, LLC

Intake Form

Name:_____ Diagnosis:_____

Reason for coming to therapy:_____

Have you had this problem before: ( )Yes ( ) No If yes explain:_____

Your goals for therapy:_____

Occupation:_____

Leisure activities/hobbies:_____

Past Medical History (Check all that apply):

( ) No Known Significant PMH To Affect Treatment

( ) Alzheimer's

( ) Cerebral Vascular Accident

( ) Current Infection

( ) Diabetes Mellitus Type 2

( ) Fracture Or Suspected Fracture

( )Huntingtons

( ) Osteoarthritis

( ) Rheumatoid Arthritis

( ) Cardiovascular Disease

( ) Muscular Dystrophy

( ) Diabetes Mellitus Type 1

( ) Fibromyalgia

( ) High Blood Pressure

( ) Cancer: What kind_____

( ) Parkinson's

( ) Traumatic Brain Injury

( )Other:_____

For Women: Are you currently or do you think you might be pregnant? ( ) Yes ( ) No

General Health:

At the present time is your health: ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Best learning style: ( ) Written ( ) Visual ( ) Verbal ( ) Other:_____

Have you recently noticed:

Weight gain or Loss? ( ) Yes ( ) No

Nausea or vomiting? ( ) Yes ( ) No

Difficulty Hearing? ( ) Yes ( ) No

Numbness or tingling? ( ) Yes ( ) No

Weakness? ( ) Yes ( ) No

Fatigue? ( ) Yes ( ) No

Have you experienced any recent falls in the past 6 months? ( ) Yes ( ) No

If yes explain: _____

Do you feel dizzy when you get up from a chair or bed ( ) Yes ( ) No

Functional Needs:

Have you had a significant decrease in your ability to perform any of the following activities in the last 3 months?

Dressing yourself (including shoes, socks, zippers, and buttons) ( ) Yes ( ) No

Grooming (including reaching to the top and behind your head) ( ) Yes ( ) No

Walking (including increased dependence on a walker or cane) ( ) Yes ( ) No

Stair Climbing ( ) Yes ( ) No

Social Service Needs:

Do you live alone? ( ) Yes ( ) No

Do you need a caregiver at home? ( ) Yes ( ) No

Are your food/ nutritional needs being met? ( ) Yes ( ) No

Have you experienced any abuse? ( ) Yes ( ) No

Medication List (Name of Med and Frequency): (May Supply A List)

_____ _____

_____ _____

_____ _____

Pain Assessment:

|__|__|__|__|__|__|__|__|__|__|__|

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Severe Pain

Are you experiencing pain now? ( ) Yes ( ) No If yes, What pain number?_____

Goals for pain relief? _____

What makes your pain worse? _____

What makes your pain better? _____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

1. Pain Intensity
(0) I can tolerate the pain I have without having to use pain medication.
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from pain.
(5) Pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)
(0) I can take care of myself normally without causing increased pain.
(1) I can take care of myself normally, but it increases my pain.
(2) It is painful to take care of myself, and I am slow and careful.
(3) I need help, but I am able to manage most of my personal care.
(4) I need help every day in most aspects of my care.
(5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting
(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights, but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. Walking
(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from walking more than 1 mile.
(2) Pain prevents me from walking more than ½ mile.
(3) Pain prevents me from walking more than ¼ mile.
(4) I can only walk with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting
(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) Pain prevents me from sitting at all.

6. Standing
(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want but, it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than 1/2 hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

7. Sleeping
(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hour.
(3) Even when I take pain medication, I sleep less than 4 hours
(4) Even when I take pain medication, I sleep less than 2 hour
(5) Pain prevents me from sleeping at all.

8. Social Life
(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

9. Traveling
(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys journeys under 1/2 hour.
(5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking
(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.

Therapist Use Only

Comorbidities:
- ☒ Cancer
- ☒ Diabetes
- ☒ Heart Condition
- ☒ High Blood Pressure
- ☒ Multiple Treatment Areas
- ☒ Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☒ Obesity
- ☒ Surgery for this Problem
- ☒ Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

ONSITE THERAPY SOLUTIONS, LLC

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Name:_____D.O.B:__/__/____

Release of Information and Consent to treat

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. I authorize that this information may be released to the following:

Spouse _____

Child(ren)_____ _____

Other_____ _____

( ) I choose to not have my information released.

This release of information will remain in effect until terminated by the patient in writing.

In the event of an emergency call:

Name:_____ Phone:_____

_____ I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist or assistant employed by onsite therapy solutions, llc.

the physical therapist has fully described to me the nature and purpose of the procedures, evaluation and/or course of treatment, and has witnessed my signature of this consent in his or her precense. The physical therapist has explained to me the possible benefits and complications of skilled physical therapy services. In addition to the benefits the therapist has explained to me the possible risks of not receiving therapy.

Patient/Guardian Printed Name:_____ Date:__/__/____

Patient Guardian Signature:_____

Therapist Signature:_____ Date: __/__/____

1801 Smucker Rd
Orrville, OH 44667

PHONE 330-685-3220
FAX 330-437-2440
EMAIL onsitetherapy@yahoo.com

ONSITE THERAPY SOLUTIONS, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Onsite Therapy Solutions, LLC** (Onsite Therapy Solutions, LLC) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among **Onsite Therapy Solutions, LLC's** personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for Onsite TherapySolutions, LLC that provides a more complete review of information uses and disclosures.

I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that Onsite Therapy Solutions, LLC may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand Onsite Therapy Solutions, LLC, for Workman's Compensation Cases, will release the minimum necessary PHI/ePHI to your employer, your worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Onsite Therapy Solutions, LLC is not required to agree to the restrictions requested. The procedure to request resfriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Onsite Therapy Solutions, LLC and agree to the liability limitations explained therein.

Signature of patient or legal representative _____ Date _____ Relationship to Patient _____

Printed name of patient _____

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