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):

( ) Cancer, what kind_____
( ) Heart Attack/ Heart problems
( ) High Blood pressure
( ) Circulation Problems
( ) Asthma
( ) Emphysema
( ) Chemical dependency (drug, alcohol)
( ) other _____
( ) Arthritis
( ) Depression
( ) Headaches
( ) Tuberculosis
( ) Stroke or TIA's
( ) Kidney disease
( ) Metal Implants/Pacemaker
( ) Thyroid Problem
( ) Diabetes
( ) Multiple Sclerosis
( ) Hepatitis
( ) Epilepsy or seizures
( ) Rheumatoid Arthritis
( ) Anemia
( ) Defibrillator
( ) Osteoporosis

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 resent 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):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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: _____

DIZZINESS HANDICAP INVENTORY – Initial Visit

Name: _____ **Date:** _____

SECTION I

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

SECTION II - Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1.	Does looking up increase your problem?	Yes[1]	No[2]	Sometimes[3]
E2.	Because of your problem, do you feel frustrated?	Yes[1]	No[2]	Sometimes[3]
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes[1]	No[2]	Sometimes[3]
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes[1]	No[2]	Sometimes[3]
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes[1]	No[2]	Sometimes[3]
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes[1]	No[2]	Sometimes[3]
F7.	Because of your problem, do you have difficulty reading?	Yes[1]	No[2]	Sometimes[3]
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes[1]	No[2]	Sometimes[3]
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes[1]	No[2]	Sometimes[3]
E10.	Because of your problem, have you been embarrassed in front of others?	Yes[1]	No[2]	Sometimes[3]
P11.	Do quick movements of your head increase your problem?	Yes[1]	No[2]	Sometimes[3]
F12.	Because of your problem, do you avoid heights?	Yes[1]	No[2]	Sometimes[3]
P13.	Does turning over in bed increase your problem?	Yes[1]	No[2]	Sometimes[3]
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes[1]	No[2]	Sometimes[3]
E15.	Because of your problem, are you afraid people might think you are intoxicated?	Yes[1]	No[2]	Sometimes[3]
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes[1]	No[2]	Sometimes[3]
P17.	Does walking down a sidewalk increase your problem?	Yes[1]	No[2]	Sometimes[3]
E18.	Because of your problem, is it difficult for you to concentrate?	Yes[1]	No[2]	Sometimes[3]
F19.	Because of your problem, is it difficult for you walk around the house in the dark?	Yes[1]	No[2]	Sometimes[3]
E20.	Because of your problem, are you afraid to stay home alone?	Yes[1]	No[2]	Sometimes[3]
E21.	Because of your problem, do you feel handicapped?	Yes[1]	No[2]	Sometimes[3]

E22.	Has your problem placed stress on your relationships with members of your family or friends?	Yes[1]	No[2]	Sometimes[3]
E23.	Because of your problem, are you depressed?	Yes[1]	No[2]	Sometimes[3]
F24.	Does your problem interfere with your job or household responsibilities?	Yes[1]	No[2]	Sometimes[3]
P25.	Does bending over increase your problem?	Yes[1]	No[2]	Sometimes[3]

SECTION II - Part II

Instructions: Put a check in the box that best describes you:

- ☐ **Negligible symptoms (0)**
- ☐ **Bothersome symptoms (1)**
- ☐ **Performs usual work duties but symptoms interfere with outside activities (2)**
- ☐ **Symptoms disrupt performance of both usual work duties and outside activities (3)**
- ☐ **Currently on medical leave or had to change jobs because of symptoms (4)**
- ☐ **Unable to work for over one year or established permanent disability with compensation payments (5)**

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

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 DO NOT** authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

( )**I DO** authorize my information shared with the following individuals or organizations (enter names below a nd initial the box):

_____

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

1801 Smucker Rd
Orrville, OH 44667

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

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: ___/____/_____

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