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
( ) Cardiovascular Disease

( ) Cerebral Vascular Accident
( ) Muscular Dystrophy

( ) Current Infection
( ) Diabetes Mellitus Type 1

( ) Diabetes Mellitus Type 2
( ) Fibromyalgia

( ) Fracture Or Suspected Fracture
( ) High Blood Pressure

( )Huntingtons
( ) Cancer: What kind_____

( ) Osteoarthritis
( ) Parkinson's

( ) Rheumatoid Arthritis
( ) 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
Numbness or tingling? ( ) Yes ( ) No

Nausea or vomiting? ( ) Yes ( ) No
Weakness? ( ) Yes ( ) No

Difficulty Hearing? ( ) 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.**

LEFS – INITIAL VISIT

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

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

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

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

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: ___/____/_____

1801 Smucker Rd
Orrville, OH 44667

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

Visitor Screening Questionnaire

In an effort to protect everyone from illness, IDOC is taking measures to prevent the spread of exposure COVID-19 in this facility. Thank you for your patience and understanding.

Please answer the following questions:

	No	Yes
I have recently traveled to a country where COVID19 (coronavirus) is spreading within the past 14 days.		
I have been in close contact with people who have traveled to countries where COVID19 (coronavirus) is spreading within the past 14 days.		
I have been around people who are sick with colds or flu.		
I have symptoms of a cold.		
I have a fever, or have had a fever within the past week.		
I have been nauseated or have vomited or had diarrhea within the past week.		

IF YOU HAVE MARKED YES TO ANY QUESTION; PLEASE POSTPONE YOUR VISIT FOR AT LEAST 14 DAYS AFTER THE START OF YOUR SYMPTOMS. Contact your healthcare provider if your symptoms get worse. Thank you for your understanding.