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

NECK DISABILITY INDEX – INITIAL VISIT

1. Pain Intensity
- (0) I have no pain at the moment.
- (1) The pain is very mild at the moment.
- (2) The pain is moderate at the moment.
- (3) The pain is fairly severe at the moment.
- (4) The pain is very severe at the moment.
- (5) The pain is the worse imaginable at the moment.

2. Personal Care (washing, dressing, etc)
- (0) I can look after myself normally without extra pain.
- (1) I can look after myself normally but it causes extra pain.
- (2) It is painful to look after myself and I am slow and careful.
- (3) I need some help but manage most of my personal care.
- (4) I need help every day in most aspects of self care.
- (5) I cannot get dressed, wash with difficulty and stay in bed

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

4. Headache
- (0) I have no headaches at all.
- (1) I have slight headaches which come infrequently.
- (2) I have moderate headaches which come infrequently.
- (3) I have moderate headaches which come frequently.
- (4) I have severe headaches which come infrequently.
- (5) I have headaches almost all the time.

5. Recreation
- (0) I am able engage in all my recreational activities without pain.
- (1) I am able to engage in my recreational activities with some pain.
- (2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
- (3) I am able to engage in a few of my usual recreational activities with some neck pain.
- (4) I can hardly do any recreational activities because of neck pain.
- (5) I can't do any recreational activities at all.

6. Reading
- (0) I can read as much as I want with no pain in my neck.
- (1) I can read as much as I want with slight neck pain.
- (2) I can read as much as I want with moderate neck pain.
- (3) I can't read as much as I want because of moderate neck pain.
- (4) I can hardly read at all because of severe neck pain.
- (5) I cannot read at all because of neck pain.

7. Work
- (0) I can do as much as I want to.
- (1) I can only do my usual work but no more.
- (2) I can do most of my usual work but no more.
- (3) I cannot do my usual work.
- (4) I can hardly do any usual work at all.
- (5) I can't do any work at all.

8. Sleeping
- (0) Pain does not prevent me from sleeping well.
- (1) My sleep is slightly disturbed (<1 hr sleep loss).
- (2) My sleep is mildly disturbed (1-2 hr sleep loss).
- (3) My sleep is moderately disturbed (2-3 hr sleep loss).
- (4) My sleep is greatly disturbed (3-4 hr sleep loss).
- (5) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration
- (0) I can concentrate fully when I want with no difficulty.
- (1) I can concentrate fully when I want with slight difficulty.
- (2) I have a fair degree of difficulty concentrating when I want.
- (3) I have a lot of difficulty concentrating when I want.
- (4) I have great difficulty concentrating when I want.
- (5) I cannot concentrate at all.

10. Driving
- (0) I can drive my car without neck pain.
- (1) I can drive my car as long as I want with slight neck pain.
- (2) I can drive my car as long as I want with moderate neck pain.
- (3) I can't drive my car as long as I want because of moderate pain.
- (4) I can hardly drive my car at all because of severe neck pain.
- (5) I can't drive my car at all.

Neck Disability Index © Vernon H. and Mior S., 1991.

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: ___/___/____

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