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

( )Other:_____

( ) Cardiovascular Disease

( ) Muscular Dystrophy

( ) Diabetes Mellitus Type 1

( ) Fibromyalgia

( ) High Blood Pressure

( ) Cancer: What kind_____

( ) Parkinson's

( ) Traumatic Brain Injury

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: _____

QuickDASH - Initial Patient name:_____ Date:_____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

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

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

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

1801 Smucker Rd
Orrville, OH 44667

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