

# Patient Summary Form



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Circle where you have pain or other symptoms:

Briefly describe your pain/symptoms: \_\_\_\_\_

How/When did your symptoms start? \_\_\_\_\_

Surgery Date: \_\_\_\_\_ Reason for Surgery: \_\_\_\_\_

Average pain intensity: last 24 hours: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

Past week: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

How often do you experience your symptoms?

- ① Constantly (76%-100% of the time)
- ② Frequently (51%-75% of the time)
- ③ Occasionally (26%-50% of the time)
- ④ Intermittently (0%-25% of the time)

How often have your symptoms interfered with your usual daily activities?

(include work outside the home and housework)

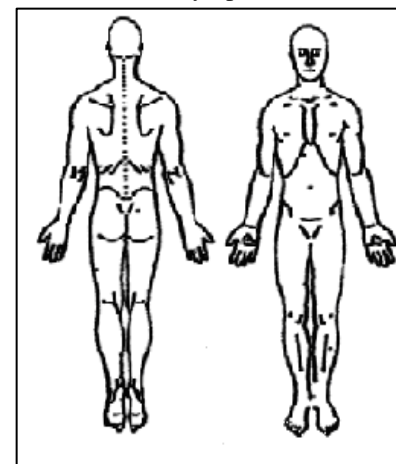
- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

How is your condition changing, since care began at *this facility*?

- ① NA – First Visit
- ② Much Worse
- ③ Worse
- ④ A little worse
- ⑤ No change
- ⑥ Better
- ⑦ Much better

In general, would you say your overall health right now is...

- ① Excellent
- ② Very good
- ③ Good
- ④ Fair
- ⑤ Poor



If accident related, please answer the following:

Type of Accident: MVA    Slip and Fall    Work Related    Other: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Day: \_\_\_\_\_ AM/PM

Location of Accident: \_\_\_\_\_

City or Town in which accident took place: \_\_\_\_\_ State: \_\_\_\_\_

Describe in Detail how the accident occurred: \_\_\_\_\_

Were you rendered unconscious as a result of the accident?    YES    NO

Were you taken to a hospital after the accident?    YES    NO

If yes, by private vehicle or ambulance? \_\_\_\_\_

If no, how much time had elapsed before you went to the hospital or doctor? \_\_\_\_\_

Which hospital were you taken to? \_\_\_\_\_

Have you lost any days from work as a result of the accident?    YES    NO

Do you have any information concerning the party held responsible for the accident?

YES    NO

Have you been contacted by an insurance company from the other party regarding this claim?

YES    NO

Are you currently represented by an attorney?    YES    NO

If yes, Attorney Name and Number? \_\_\_\_\_

If no, do you wish to retain an attorney?    YES    NO

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Rehab Management Physical Therapy  
 Medical History/Social Questionnaire



Patient Name: \_\_\_\_\_ D/O/B \_\_\_\_\_

Do you now or have you ever had any of the following? (Check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> High Blood Pressure          |
| <input type="checkbox"/> Heart Disease                   | <input type="checkbox"/> Heart Attack       | <input type="checkbox"/> Pacemaker / Surgical Implant |
| <input type="checkbox"/> Vascular Disease                | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Kidney Problems              |
| <input type="checkbox"/> Open Wounds                     | <input type="checkbox"/> Current Infections | <input type="checkbox"/> Allergies                    |
| <input type="checkbox"/> Hernia                          | <input type="checkbox"/> Seizures           | <input type="checkbox"/> Metal In Body                |
| <input type="checkbox"/> Cancer / Tumor                  | <input type="checkbox"/> Thyroid Problems   | <input type="checkbox"/> CVA / Stroke                 |
| <input type="checkbox"/> Previous Fractures              | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Depression                   |
| <input type="checkbox"/> Anxiety                         | <input type="checkbox"/> Substance Abuse    | <input type="checkbox"/> Previous Surgeries           |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Presently Pregnant | <input type="checkbox"/> Hepatitis (A, B, C)          |
| <input type="checkbox"/> Hypersensitivity to Heat / Cold |   | <input type="checkbox"/> Other (_____)                |

Explanation & approximate date: \_\_\_\_\_

Are you presently taking medications? Yes / No

If yes, list medications & specify condition \_\_\_\_\_

Do you currently have transportation to and from Physical Therapy? Yes / No

Do you currently have financial difficulties that would prohibit you from coming to Physical Therapy? Yes / No

Are you currently – please circle one of the following:

Employed    Unemployed    Retired-Date \_\_\_\_\_    Disabled-Date \_\_\_\_\_

Are you currently receiving, or in the last 30 days, have you received Home Health (HH) services from anyone for any type of procedure? Yes / No

**\*Please notify front desk if you have received or are receiving Home Health.**

If yes, please write Agency name, Phone number and doctor's name who ordered Home Health.

Agency Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Date HH began: \_\_\_\_\_

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\_\_\_\_\_  
 Patient / Guardian Signature

\_\_\_\_\_  
 Date

Rehab Management  
Social / Vocational Questionnaire



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

The following is a list of questions designed to aid in your physical rehabilitation. They are not designed to embarrass or pry, merely to assess any needs you might have. The answers will be kept confidential. You do not have to answer any question or questions, at your discretion.

1. Do you currently have transportation to and from Physical Therapy? Yes / No
2. Do you currently have financial difficulties that would prohibit you from coming to Physical Therapy? Yes / No
3. Are you currently experiencing any anxiety or depression about or from Physical Therapy? Yes / No
4. Are you currently in need of any psychological counseling? Yes / No
5. Are you currently – please circle one of the following:  
Employed      Unemployed      Retired-Date\_\_\_\_\_      Disabled-Date\_\_\_\_\_
6. Are you currently receiving, or in the last 30 days, have you received Home Health services from anyone for any type of procedure? Yes / No

If yes, please write Agency name, Phone number and Nurse name:

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\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

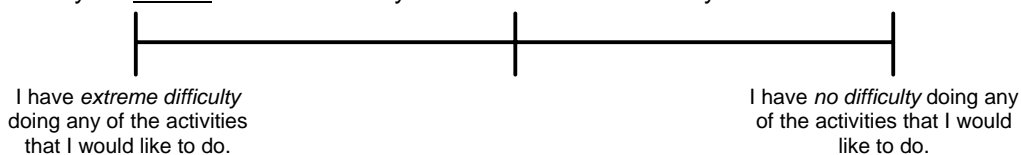
# OPTIMAL INSTRUMENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Difficulty–Baseline - Evaluation

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an “X” at the point on the line that best describes your overall level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13 )

1. \_\_\_\_ 2. \_\_\_\_ 3. \_\_\_\_

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Adapted/ revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther*. 2005;85:515-530.





***Regarding Insurance & Payment Policy***

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We must emphasize that as physical therapy providers, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. It is our policy to call and verify benefits and eligibility in order for us to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed, at which time there may be a balance due on your account. In the event that this occurs we will mail you a statement and appreciate your prompt payment. We will accept the contracted rate & take the necessary adjustments if we are a participating provider with your insurance. Payment for service is due prior to or upon completion of each treatment visit. We accept cash, checks, Mastercard, Visa & American Express. Once your complete insurance information is on file, we will be happy to submit your claims to your insurance company.

***Non-covered Expenses***

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment of charges denied due to an insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance company does not cover due to limitations of the policy or what they consider reasonable and necessary. It is your responsibility to know what the policy limits are. Our goal is to improve your condition successfully based on what the doctor and the physical therapist deem reasonable and necessary treatment, not on what your policy limits are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses.

***Consent and Acknowledgement of Receipt of Privacy Notice (HIPAA)***

I understand that as part of the provision of healthcare services, **Rehab Management Physical Therapy** creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations, be restricted. I also understand that the practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

***Consent to Treat, Assignment of Benefits & Release of Information***

The undersigned consents to be (have minor) treated by Rehab Management on an outpatient basis, which includes services rendered under the general and specific instructions of patient's physician or surgeon. The undersigned hereby assigns to Rehab Management all payments for services rendered to patient. The undersigned understands and accepts responsibility for any amount not covered by insurance, except in workers' compensation claims. I hereby authorize Rehab Management to furnish any and all information concerning my (minor's) treatment or illnesses to my (minor's) insurance carriers, attorney or other health professionals. I further authorize any holder of medical or other information about me (minor) pertaining to my (minor's) treatment or diagnosis to release it to Rehab Management.

\_\_\_\_\_  
Patient Signature (Parent or Guardian Signature if Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date