

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

Patient's Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please complete the following questions to the best of your ability. This will help us to develop a treatment with you that meet your individual needs.

1. Reason for your visit today? \_\_\_\_\_

2. Date of injury of when problem last caused you to seek medical attention: \_\_\_\_\_

3. How did your current problem begin?  Lifting  Twisting  Falling  Car Accident  Unknown  
 Other: \_\_\_\_\_

4. Were you hospitalized for this problem?  Yes  No  
If yes, please give dates: \_\_\_\_\_

5. Are you currently being seen by any of the following?  Dentist  Chiropractor  Osteopath  
 Physical Therapist  Occupational Therapist  Psychiatrist / Psychologist  
If you are seeing any of the above, please describe the reason: \_\_\_\_\_

6. What can you no longer do because of your current illness or accident? \_\_\_\_\_

7. Please mark the areas where you have seen a **decline in your abilities since your most recent illness:**  
 Getting in or out of bed  Getting in or out of chairs  Walking/Balance  
 Eating  Dressing  Grooming  
 Lifting  Bending  Other: \_\_\_\_\_

8. Are you experiencing pain due to your current accident or illness?  Yes  No  
Using the following scale, with 1 being the least amount of pain and 10 being very severe pain, please rate your pain **during rest:** (please circle)  
1    2    3    4    5    6    7    8    9    10

Using the same scale, please rate your pain **during activity:** (please circle)  
1    2    3    4    5    6    7    8    9    10

9. Have you had therapy for this recent illness?  Yes  No  
If yes, please explain where and when, and the outcome of the therapy: \_\_\_\_\_

10. Are you presently working?  Yes  No  
Occupation: \_\_\_\_\_

11. Are you:  Right Handed  Left Handed

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

12. Do you use a :     Cane     Walker     Other: \_\_\_\_\_     None

13. What type of exercise are you currently doing? \_\_\_\_\_  
\_\_\_\_\_

14. How, if at all, have your exercise and daily activities changed due to your recent illness? \_\_\_\_\_  
\_\_\_\_\_

15. Rate your stress over the past 4 weeks: (please circle)

No Stress    1    2    3    4    5    6    7    8    9    10    High Stress

16. Any recent significant change in your appetite?     Yes     No

17. Do you currently experience any of the following?

- |                                              |                                               |                                                   |
|----------------------------------------------|-----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Cardiac Problems    | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hypertension             |
| <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> GI problems              |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Multiple Sclerosis       |
| <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Depression           | <input type="checkbox"/> Drug /Alcohol Dependency |

18. Have you ever had a broken bone or fracture?     Yes     No

If yes, which body part(s): \_\_\_\_\_ When? \_\_\_\_\_

19. Do you smoke?     Yes     No

20. Are you pregnant?     Yes     No

21. List any medical allergies: \_\_\_\_\_

22. List all prescription or over-the-counter medications you are currently taking if you have not currently provided this information already: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. What would you like to learn more about related to your current illness /injury? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. Do you have problems with any of the following?

- Caring for yourself     Obtaining Meals     Keeping Appointments

25. Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_



## FAQ's (Frequently Asked Questions)

Upon starting your Physical Therapy or Hand Therapy program you may have several questions. We will try to answer many of them below:

- 1) **What should I wear?** For individual comfort and convenience you should wear clothes you would be comfortable exercising in, including appropriate footwear. Sandals, heels, and other open toed shoes are discouraged. Additionally, consider garments that will allow for the discreet exposure of the area you are having treated.
- 2) **Can I bring my children or spouse?** Due to privacy laws we encourage only a direct caregiver or parent be present for treatments. Additionally, our facility contains extremely tempting equipment for children to play on. In the interest of safety we require all non-treating children to remain in the reception area with adult supervision.
- 3) **Do I need a towel?** For your convenience we have towels at your disposal. However, we do not have a shower facility in all of our locations. At times your therapy may consist of moderate levels of exertion, and/or application of thermal, electrical, and ultrasonic modality. Therefore, we urge all Therapy participants to refrain from personal application of lotions and perfumes as they may interfere with your treatment program.
- 4) **Do you bill my insurance?** As a courtesy our reception staff verifies insurance eligibility and benefits prior to undergoing therapy treatment. Many insurance plans have co-pays, co-insurance, and deductibles. We encourage you to check your individual policy and limitations and/or pre-authorization requirements as outlined in your "Eligibility of Benefits" handbook. Patients should check with our receptionists on a weekly basis to evaluate their account. Please notify our office immediately if your insurance plan changes. Failure to do so may result in nonpayment of insurance claims for all therapy charges.
- 5) **How long will my therapy sessions last?** Typically, you can expect each session to last between 45 and 60 minutes. To ensure that your therapy time is maximized we request cell phones and pagers be turned off prior to your therapy appointment.
- 6) **Do I need to make an appointment?** Yes. Please make appointments at our reception desk 1-2 weeks in advance to ensure a convenient schedule for you. If you must cancel an appointment, kindly give 24 hours notice and every effort will be made to reschedule your visit at a convenient time. If you are insured by worker's compensation insurance we are required to inform your adjustor or nurse case manager of any missed appointments.

**EACH PATIENT (OR RESPONSIBLE PARTY) IS FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED. WHILE WE ARE PLEASED TO PREPARE INSURANCE FORMS, THE OBLIGATION FOR PAYMENT OF OUR FEES REMAINS THAT OF THE PATIENT.**

**FEES FOR ANY PHYSICIAN, MRI, BONE DENSITOMETRY, ETC. WILL BE BILLED SEPARATELY FROM YOUR THERAPY FEES.**

I have read and understand the above information.

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Patient/Parent Signature

Printed Name

Date



## FAQ's Addendum

- **Am I responsible for payment at the time of service?** If you have a co-pay you will be responsible for payment before services are given. If you have a co-insurance, we will be happy to bill you after we receive notification from your insurance company. If your insurance is out of network with our office, all payment will be due at the time of service.
- **Will I be charged for any supplies I receive?** Money for any supplies must be collected at the time of purchase. You may be able to get reimbursed by your insurance company, but we do not bill supplies to insurance companies. We will be happy to provide you with the necessary paperwork for you to submit to your insurance company. If your insurance is through Workers Compensation, we will not charge you for any supplies you receive.
- **Are there consequences for arriving late or missing appointments?** Please make every effort to arrive on time. Late arrivals put stress on the therapist to meet all their patients' needs. We recognize that some appointments cannot be kept due to unforeseen circumstances. However, we ask for 24-hour notice so that the time can be re-booked for another client. Our policy is to charge \$50 for an appointment that is missed without the courtesy of a call, and \$25 for appointments that are canceled with less than 24 hours notice. Workers Compensation adjusters will be notified of each offense.

**I have read and understand the above information.**

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**Patient/Parent Signature**

**Printed Name**

**Date**

3525 loma vista road  
ventura, ca 93003

2100 solar drive, suite 100  
oxnard, ca 93036

3695 alamo street, suite 101  
simi valley, ca 93063

115 pirie road, suite c  
ojai, ca 93023

2230 lynn road, suite 220  
thousand oaks, ca 91360

805.652.6955/fax 805.652.6959

805.988.0448/fax 805.988.3070

805.526.2311/fax 805.526.6608

805.640.1631/fax 805.640.1452

805.379.4574/fax 805.379.4324

805.641.6429/fax 805.641.6495



Ventura Orthopedics

Therapy Services

### CONSENT FOR TREATMENT

I hereby authorize the providers at Ventura Orthopedics to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Representative Signature

### Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Ventura Orthopedics for any services furnished me by the therapists. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Date

### Insurance Authorization for Assignment of Benefits/Information Release

I, the undersigned authorize payment of medical benefits to Ventura Orthopedics for any services furnished me by the provider. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Date

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

**Section I: To be Completed by Patient**

**Patient Initials:** \_\_\_\_\_

**Number of Days of Back Pain:** \_\_\_\_\_ **(this episode)**

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only one line which most closely describes your current condition.**

**Pain Intensity**

- \_\_\_\_\_ The pain is mild and comes and goes.
- \_\_\_\_\_ The pain is mild and does not vary much.
- \_\_\_\_\_ The pain is moderate and comes and goes.
- \_\_\_\_\_ The pain is moderate and does not vary much.
- \_\_\_\_\_ The pain is severe and comes and goes.
- \_\_\_\_\_ The pain is severe and does not vary much.

**Personal Care (Washing, Dressing, etc.)**

- \_\_\_\_\_ I do not have to change the way I wash and dress myself to avoid pain.
- \_\_\_\_\_ I do not normally change the way I wash or dress myself even though it causes some pain.
- \_\_\_\_\_ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- \_\_\_\_\_ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- \_\_\_\_\_ Because of my pain, I am partially unable to wash and dress without help.
- \_\_\_\_\_ Because of my pain, I am completely unable to wash and dress without help.

**Lifting**

- \_\_\_\_\_ I can lift heavy weights without increased pain.
- \_\_\_\_\_ I can lift heavy weights, but it causes increased pain.
- \_\_\_\_\_ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g., on a table, etc.)
- \_\_\_\_\_ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- \_\_\_\_\_ I can only lift very light weights.
- \_\_\_\_\_ I can not lift or carry anything at all.

**Walking**

- \_\_\_\_\_ I have no pain when walking.
- \_\_\_\_\_ I have pain when walking, but I can still walk my required normal distances.
- \_\_\_\_\_ Pain prevents me from walking long distances.
- \_\_\_\_\_ Pain prevents me from walking intermediate distances.
- \_\_\_\_\_ Pain prevents me from walking even short distances.
- \_\_\_\_\_ Pain prevents me from walking at all.

**Sitting**

- \_\_\_\_\_ Sitting does not cause me any pain.
- \_\_\_\_\_ I can only sit as long as I like providing that I have my choice of seating surfaces.
- \_\_\_\_\_ Pain prevents me from sitting for more than one hour.
- \_\_\_\_\_ Pain prevents me from sitting for more than 1/2 hour.
- \_\_\_\_\_ Pain prevents me from sitting for more than 10 minutes.
- \_\_\_\_\_ Pain prevents me from sitting at all.

**Standing**

- \_\_\_\_\_ I can stand as long as I want without increased pain.
- \_\_\_\_\_ I can stand as long as I want, but my pain increases with time.
- \_\_\_\_\_ Pain prevents me from standing more than 1 hour.
- \_\_\_\_\_ Pain prevents me from sitting for more than 1/2 hour.
- \_\_\_\_\_ Pain prevents me from sitting for more than 10 minutes.
- \_\_\_\_\_ I avoid standing because it increases my pain right away.

**Sleeping**

- \_\_\_\_\_ I get no pain when I am in bed.
- \_\_\_\_\_ I get pain when I am in bed, but it does not prevent me from sleeping well.
- \_\_\_\_\_ Because of my pain, my sleep is only 3/4 of my normal amount
- \_\_\_\_\_ Because of my pain, my sleep is only 1/2 of my normal amount.
- \_\_\_\_\_ Because of my pain, my sleep is only 1/4 of my normal amount.
- \_\_\_\_\_ Pain prevents me from sleeping at all.

**Social Life**

- \_\_\_\_\_ My social life is normal and does not increase my pain.
- \_\_\_\_\_ My social life is normal, but it increases my level of pain.
- \_\_\_\_\_ Pain prevents me from participating in more energetic activities (e.g., sports, dancing, etc.)
- \_\_\_\_\_ Pain prevents me from going out at all.
- \_\_\_\_\_ Pain has restricted my social life to my home.
- \_\_\_\_\_ I have hardly any social life because of my pain.

**Traveling**

- \_\_\_\_\_ I have no pain when traveling.
- \_\_\_\_\_ I get some pain when traveling, but none of my usual forms of travel make it any worse.
- \_\_\_\_\_ I get increased pain when traveling, but it does not cause me to seek alternative forms of travel.
- \_\_\_\_\_ I get increased pain when traveling, which causes me to seek alternative forms of travel.
- \_\_\_\_\_ My pain restricts all forms of travel, except that which is done while I'm lying down.
- \_\_\_\_\_ My pain restricts all forms of travel.

**Employment/Homemaking**

- \_\_\_\_\_ My normal job/homemaking activities do not cause pain.
- \_\_\_\_\_ My normal job/homemaking activities increase my pain, but I can still perform all that is required of me.
- \_\_\_\_\_ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- \_\_\_\_\_ Pain prevents me from doing anything but light duties.
- \_\_\_\_\_ Pain prevents me from doing even light duties.
- \_\_\_\_\_ Pain prevents me from performing any job or homemaking chores.

**Section II: To be Completed by Physical Therapist/Provider**

**SCORE: Initial \_\_\_\_\_ %      Subsequent \_\_\_\_\_ %      Subsequent \_\_\_\_\_ %      Discharge \_\_\_\_\_ %**

**Date: \_\_\_\_\_      Date: \_\_\_\_\_      Date: \_\_\_\_\_**

**Number of Treatment Sessions: \_\_\_\_\_      Diagnosis/ICD-9 Code: \_\_\_\_\_**