Ventura Orthopedics Medical Group, Inc.
www.venturaortho.com

Rehabilitation Screening / Confidential Medical History

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

Please continue on reverse side.

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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?

❑ Cardiac Problems ❑ Diabetes ❑ Hypertension
❑ Orthopedic Problems ❑ Rheumatoid Arthritis ❑ GI problems
❑ Cancer ❑ Seizures ❑ Multiple Sclerosis
❑ Fibromyalgia ❑ Depression ❑ 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.

____________________	____________________	__________
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.

____________________	____________________	__________
Patient/Parent Signature	**Printed Name**	**Date**

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

Ventura Orthopedics

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Lower Extremity Functional Scale

Patient Name: ______________________ Date: __________

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb** problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, **do you** or **would you** have difficulty at all with:

Activities	**Extreme Difficulty or Unable to Perform Activity**	**Quite a Bit of Difficulty**	**Moderate Difficulty**	**A Little Bit of Difficulty**	**No Difficulty**
a. Any of your usual work, housework or school activities	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Getting into or out of the bath	0	1	2	3	4
d. Walking between rooms	0	1	2	3	4
e. Putting on your shoes or socks	0	1	2	3	4
f. Squatting	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
h. Performing light activities around your home	0	1	2	3	4
i. Performing heavy activities around your home	0	1	2	3	4
j. Getting into or out of a car	0	1	2	3	4
k. Walking 2 blocks	0	1	2	3	4
l. Walking a mile	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
n. Standing for 1 hour	0	1	2	3	4
o. Sitting for 1 hour	0	1	2	3	4
p. Running on even ground	0	1	2	3	4
q. Running on uneven ground	0	1	2	3	4
r. Making sharp turns while running fast	0	1	2	3	4
s. Hopping	0	1	2	3	4
t. Rolling over in bed	0	1	2	3	4
COLUMN TOTALS:					

SCORE: [1-(___ /80] x 100