

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**

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**Printed Name**

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**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 piñe 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: \_\_\_\_\_

Please rate your ability to do the following activities in the last week by circling the numbers below the appropriate response.

Activities	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 & needles) in your arm, shoulder or hand.	1	2	3	4	5

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	So Much, Unable to 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

QuickDASH DISABILITY/SYMPTOM SCORE =  $\left[ \left( \frac{\text{sum of } n \text{ responses}}{n} \right) - 1 \right] \times 25$  where *n* is equal to the number of completed responses.

A QuickDASH score may **not** be calculated if there is greater than 1 missing item.