ORTHOPEDIC & SPORTS
PHYSICAL THERAPY

11330 Maple Brook Dr | Louisville, KY | 40241
Tel: 502.426.2221 | **Fax:** 502.426.2210

1868 Plaudit Place, Suite B | Lexington, KY | 40509
Tel: 859.264.0512 | **Fax:** 859.264.0595

Orthopedic & Sports Physical Therapy would like to take this opportunity to welcome you to our clinic. It is our goal to provide you with the highest level of care possible at convenient appointment times to meet your busy schedule. Our service will be at the core of how we treat patients and their families. We understand the importance of your condition and your need to return to your previous function. We will work toward those goals with a high intensity. We are open Monday through Friday 7:00 AM – 6:00 PM to meet your scheduling needs. Your compliance with the plan of care discussed with your therapist is very important to the recover process. If you have to miss a scheduled appointment please contact our office so that we can re-schedule to meet your therapy needs. We want each person that enters our clinic to feel at home. If you have any questions or concerns, please feel free to discuss these items with either Bradley or Jim. Again, thank you for allowing Orthopedic & Sports Physical Therapy to provide your PT services and we hope that you are completely satisfied with your care.

Thanks,

Bradley Wheeldon

Jim Rothbauer

ORTHOPEDIC & SPORTS PHYSICAL THERAPY

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1) Used and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment, and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians, and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company including Medicare and Medicaid so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at your facility or for business planning activities.

Other Special Uses

Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do not agree, we must abide by your request.

Confidential Communications

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments

You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied without response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice of required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

ORTHOPEDIC & SPORTS PHYSICAL THERAPY

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (printed name of patient or personal representative)

acknowledge that I have received a copy of the Notice of Privacy Practices of Orthopedic & Sports Physical

Therapy, PLLC for ____me or ____ specify patient name _____.

_____ _____ _____

Signature of Patient or Personal Representative Date Relationship to Patient

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Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request appointment, medical and or billing and account information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow Orthopedic & Sports Physical Therapy to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize Orthopedic & Sports Physical Therapy to release any of the information stated above to the following individual(s):

1. _____ Relation to Patient:_____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient:_____

Patient Name: _____

Patient Signature: _____ Date:_____

ORTHOPEDIC & SPORTS PHYSICAL THERAPY

INTAKE INFORMATION FORM

Patient Name: _____
Last First M.I.

Address: _____
Street or P.O Box City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Male: ☐ Female: ☐ Preferred Language: _____

Ethnicity: Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to Answer ☐ Race: _____

Patient Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Spouse's Name: _____ Work/Cell: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Referring Doctor: _____ Date Last Seen: _____

Primary Care Doctor: _____ Date Last Seen: _____

Other Referral: _____

How Did You Hear About Us?

☐ Newspaper ☐ Google ☐ Yellow Pages ☐ Magazine ☐ Social Media

☐ Our Website ☐ Other Website ☐ Family/Friend ☐ MD Referral ☐ Other _____

ADDITIONAL INFORMATION

Patient Employer: _____ Retired: _____

Address: _____ Phone: _____

Are you a student? Yes ☐ No ☐ Full Time ☐ Part Time ☐

Person Financially Responsible: _____ Phone: _____

Address: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy #: _____

Group #: _____

Is Patient the Subscriber? Yes ☐ No ☐

Subscriber Name: _____

Subscriber Employer: _____

S.S.#: _____

Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance: _____

Policy #: _____

Group #: _____

Is Patient the Subscriber? Yes ☐ No ☐

Subscriber Name: _____

Subscriber Employer: _____

S.S.#: _____

Date of Birth: _____

Relationship to Patient: _____

INJURY OR ONSET OF PAIN INFORMATION

Date of Onset/Injury: _____ Diagnosis: _____

Injury Occurred At: Home ☐ Work ☐ School ☐ MVA/Auto ☐

If Work Injury/Auto Accident, has incident been reported? Yes ☐ No ☐

Insurance Adjuster's Name: _____ Phone: _____

Claim #: _____

Attorney Name: _____ Phone: _____

Have you had physical & occupational therapy/chiropractic care this year? Yes ☐ No ☐

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Subjective History / Report
Past Medical History

Demographics:

Patient Name: _____ Date of Eval: _____

Date of Birth: _____ Male: ☐ Female: ☐ Date of Onset: _____

Diagnosis: _____ Surgical Procedure: _____

Referring Physician: _____ Date of Surgery: _____

Subjective History:

What was the date of your injury / onset of symptoms? _____

How did you injure yourself? _____

_____

Have you had any of the following? ☐ X-Ray ☐ CT Scan ☐ MRI ☐ EMC/NCV

__ Other special Testing including: _____

Last physician appointment? _____ Next physician appointment? _____

Have you had any prior occurrence of this condition or treatment for this condition? Yes ☐ No ☐

Please explain: _____

Current Complaints:

What is your chief complaint? _____

_____

What makes your pain better? _____

What makes your pain worse? _____

Prior Level of Function:

What were you able to do prior to this injury that you are not able to do presently? _____

_____

Pain Rating:

If you have pain, what is your pain level? (0 = No Pain, 10 = Extreme Pain)

Pain Level at **WORST**: (Circle)

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|
0 1 2 3 4 5 6 7 8 9 10

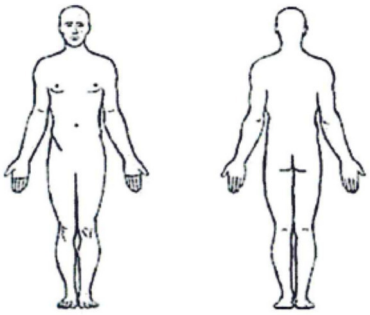
CURRENT Pain Level: (Circle)

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|
0 1 2 3 4 5 6 7 8 9 10

Pain Level at **BEST**: (Circle)

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|
0 1 2 3 4 5 6 7 8 9 10

Please mark the location of pain with an "X"



ORTHOPEDIC & SPORTS PHYSICAL THERAPY

Subjective Report/PMHX Form

Patient Name: _____ Date: _____

Information requested regarding current condition:

Occupation / Work Status: What is your occupation? _____

Are you currently working? Yes ☐ No ☐

Are you now, or ever have been disabled (service or work)? Yes ☐ No ☐ When? _____

Social History / Interests / Living Environment:

Do you live: ☐ Alone ☐ With Spouse ☐ With Family ☐ Other: _____

Do you have stairs? Yes ☐ No ☐ How many? _____ Handrails? _____

Do you have any home fall hazards such as throw rugs, poor lighting, etc. Yes ☐ No ☐

How are your interests/hobbies affected by your symptoms? _____

Previous Medical History / General Health / Prior Hospitalizations:

How would you classify your general health: Good ☐ Fair ☐ Poor ☐

Do you have or have you ever had any of the following?

☐Allergies	☐Fibromyalgia	☐Liver/Gallbladder Problems	☐Recent Fractures
☐Anemia	☐Headaches	☐Metal Implants	☐Rheumatoid Arthritis
☐Asthma / Breath Diff.	☐Heart Attack	☐Nausea / Vomiting	☐Ringing In Ears
☐Bowel/Bladder Diff.	☐Heart Disease	☐Night Pain	☐Seizures / Epilepsy
☐Cancer	☐Heart Palpitations	☐Osteoarthritis	☐Sexual Dysfunction
☐Chest Pain/Angina	☐Hernia	☐Osteoporosis	☐Skin Abnormalities
☐Depression	☐High/Low BP	☐Pacemaker	☐Smoking History
☐Diabetes I or II	☐Hypoglycemia	☐Physical Abnormalities	☐Stroke / TIA
☐Dizziness / Fainting	☐Intolerance to Cold	☐Intolerance to Heat	☐Polio
☐Surgeries	☐Fever	☐Kidney Problems	☐Pregnancy (Currently)
	☐Urine Leakage	☐Vision Changes	

Is there any other information regarding your medical history that we should know about? _____

Medical Precautions / Contraindications:

Are there any factors that may complicate your ability to participate in therapy? Yes ☐ No ☐

If yes, please explain: _____

Have you fallen in the past 12 months? Yes ☐ No ☐ If so, how many times? _____

If yes, please describe the nature of the fall(s): _____

Do you currently or have you in the past used an assistive walking device to walk with? Yes ☐ No ☐

If yes, list the device (i.e. case, walker, wheelchair, etc): _____

Medications: Please list all of the medications (with specific dosages) that you are currently taking (including over-the-counter, prescriptions, herbals, and vitamins/minerals): _____

Patient's Goals for PT: What are your goals for participating in therapy? _____

Patient Signature: _____

To the best of my knowledge, I have fully informed you of the history of my problem and current status.

Therapist Signature: _____

THE Quick DASH

OUTCOME MEASURE

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.

Quick DASH

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

	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

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY 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

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is: _____

☐ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Using your usual technique for your work?	1	2	3	4	5
2. Doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. Doing your work as well as you would like?	1	2	3	4	5
4. Spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both.* If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you: _____

☐ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. Playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. Playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. Spending your usual amount of time practicing or playing your instrument or sport?	1	2	3	4	5