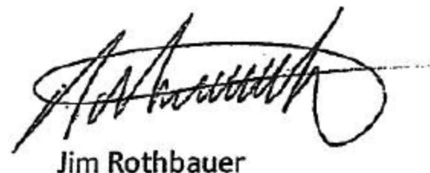
ORTHOPEDIC & SPORTS
PHYSICAL THERAPY

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,



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.

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:

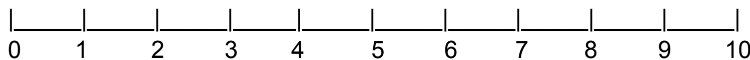
What were you able to do prior to this injury that you are not able to do presently? _______________________

____

Pain Rating:

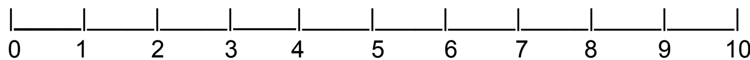
If you have pain, what is your pain level? (0 = No Pain, 10 = Extreme Pain)

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



0 1 2 3 4 5 6 7 8 9 10

CURRENT Pain Level: (Circle)

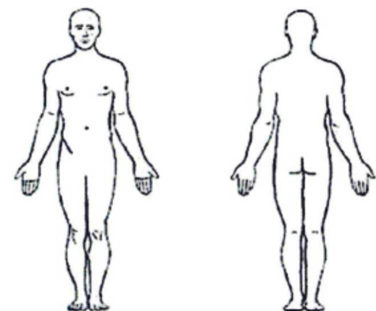


0 1 2 3 4 5 6 7 8 9 10

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"



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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: ______________________________

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 2 kilometres
- ☐ Pain prevents me from walking more than 1 kilometre
- ☐ Pain prevents me from walking more than 500 metres
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Score: / x 100 = %

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated: 16 (total scored)
45 (total possible score) x 100 = 35.5%

Minimum Detectable Change (90% confidence): 10%points (Change of less than this may be attributable to error in the measurement)

Source: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. *Spine*, 25(22):2940-2953.
Davidson M & Keating J (2001) A comparison of five low back disability questionnaires: reliability and responsiveness. Physical Therapy 2002;82:8-24.

*Note: Distances of 1mile, ½ mile and 100 yards have been replaced by metric distances in the Walking section.