

Patient ID:	Patient Proxy:	Body Part:	<input type="checkbox"/> Multi sites
Survey Date:	Primary Clinician:	Impairment Category:	<input type="checkbox"/> Multiple categories
Payer Source:	Care Type:	Sex:	Insurance:
Patient Last:	Patient First:	Patient DOB:	Physician:

MEDICAL HISTORY & GOAL

Name of recent "HOME HEALTH CARE" provider: Not applicable

Home care provider discharge date: _____ Home Health Care Phone No: _____

For patients 17 years or younger, is immunization/vaccination status current? Yes No

I am currently: Full Duty Modified Duty Light Duty Off Work Medical leave

Interests/hobbies are: _____

Is there anyone who can assist you with doing home exercises or activities if needed? Yes No

MEDICATIONS: I have provided a copy of my medication(s) list; Please see back

Over the counter pain reliever(s): _____

Daily vitamins or supplement(s): _____

Specific vitamin(s): _____

What do you WANT TO achieve from having therapy? (check all that apply)

<input type="checkbox"/> Improve home activities	<input type="checkbox"/> Improve mobility/walking activities	<input type="checkbox"/> Decrease or eliminate pain/discomfort
<input type="checkbox"/> Improve leisure/sports activities	<input type="checkbox"/> Improve ability to communicate	<input type="checkbox"/> Return to work: <input type="checkbox"/> Current <input type="checkbox"/> Other
<input type="checkbox"/> Improve self care activities	<input type="checkbox"/> Improve swallowing	<input type="checkbox"/> Other: _____

Please include any additional information you feel would help us provide your care (i.e. What you think would help, any apprehensions about treatment, spiritual or cultural needs, etc.):

POLICIES and PROCEDURES

MEDICAL RECORDS: Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Regardless of any claim pending, I will receive periodic statement(s) if my account has an outstanding balance. *Sports Arena Physical Therapy cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim.*

Sports Arena Physical Therapy owns my medical records and I may obtain a photocopy for a copy fee.

AN ADDITIONAL \$25 FEE WILL BE APPLIED FOR THE FOLLOWING:

I UNDERSTAND that If I am **more than 15 minutes late** for an appointment I may need to stand by OR may need to be rescheduled (late reschedules are considered as a LATE CANCELLATION).

I UNDERSTAND that **LATE CANCELLATIONS** (less than 24 hour notice) & **NO SHOWS** should I cancel less than 24-hours prior to my appointment. (Voice mail will note the time and date of notification if office is closed.)

I UNDERSTAND that if I should walk out on any scheduled appointment prior to treatment and will be considered as a **LATE CANCELLATION**.

CONSISTENT CANCELLATIONS AND RESCHEDULES: I UNDERSTAND that **CONSISTENT lateness, cancellations, reschedules, and/or no shows** will result in the **loss of all previously scheduled future appointments AND time and therapist preferences**. All new appointments will be allowed on a "first come, first-serve bases" for the current week ONLY.

THERAPIST OF CHOICE: I UNDERSTAND the **THERAPIST OF MY CHOICE IS NOT ALWAYS AVAILABLE** and will **concede treatment with a licensed therapist provided. If I do not concede I understand a \$25 late cancellation fee will be applied to my account. I understand that Sports Arena Physical Therapy will to try to schedule the licensed THERAPIST OF CHOICE for most treatments.**

LATE START: I UNDERSTAND that **if my treatment will begin later than appointment** I have the option to wait and will receive the 45 minute minimum treatment OR may reschedule another appointment either later the same day or week and an additional fee **WILL NOT** be applied for the change.

I understand and acknowledge the above information).

PATIENT or LEGAL RESPONSIBLE SIGNATURE and DATE (6/08)

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PATIENT SELF EVALUATION SURVEY

GENERIC

What is your primary complaint?

1. Have you received treatments for this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Evaluation Date:	Discharge Date:						
<p>As of today, help us understand whether you are having difficulty with the activities listed below, please provide an answer for each activity. If you do not perform an activity, select Not Applicable.</p>	<table border="0" style="width:100%; text-align: center;"> <tr> <td>Limited a lot</td> <td>Limited a little</td> <td>Not limited</td> </tr> </table>	Limited a lot	Limited a little	Not limited	<table border="0" style="width:100%; text-align: center;"> <tr> <td>Limited a lot</td> <td>Limited a little</td> <td>Not limited</td> </tr> </table>	Limited a lot	Limited a little	Not limited
Limited a lot	Limited a little	Not limited						
Limited a lot	Limited a little	Not limited						
2. Participating in rigorous sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Lifting 100 lbs or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Vigorous activities (running more than 5 miles, lifting heavy objects, sports)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Participating in recreation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. Moderate activities (moving a table or pushing a vacuum cleaner)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7. Climbing several flights of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8. Climbing one flight of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
9. Walking more than a mile?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
10. Walking several blocks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
11. Walking one block?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
12. Walking around a room?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
13. Going on vacation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
14. Attending social events?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
15. Lifting or carrying items (groceries, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
16. Lifting overhead to a cabinet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
17. Gripping or opening a can?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
18. Handling of small items (coins, pens, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
19. Feeding yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
20. Getting in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
21. Bathing or dressing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
22. Bending to the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
23. Kneeling to the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
24. Control of your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
25. Completing your toiletries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
26. Do you limit the kind of work or other daily activities as a result of your physical health?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
27. Do you reduce the amount of time you spend on work or other regular daily activities as a result of your physical health?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
28. How much does pain interfere with your normal work (including work outside the home, around the yard, and housework)?	<input type="checkbox"/> Extremely <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Moderately <input type="checkbox"/> Not at all	<input type="checkbox"/> Extremely <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Moderately <input type="checkbox"/> Not at all				
29. How much pain have you had in the past 24 hours?	<input type="checkbox"/> Severe <input type="checkbox"/> Moderate	<input type="checkbox"/> Mild <input type="checkbox"/> None	<input type="checkbox"/> Severe <input type="checkbox"/> Moderate	<input type="checkbox"/> Mild <input type="checkbox"/> None				
30a. Are you taking prescription medication for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
30b. Please rate your overall change during the treatment for this condition:			Worse <input type="checkbox"/> -7 <input type="checkbox"/> -6 <input type="checkbox"/> -5 <input type="checkbox"/> -4 <input type="checkbox"/> -3 <input type="checkbox"/> -2 <input type="checkbox"/> -1 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 Better					
31. How often have you completed at least 20 minutes of exercise (jogging, cycling, brisk walking)?	<input type="checkbox"/> At least 3 times a week <input type="checkbox"/> Once or twice a week <input type="checkbox"/> Seldom or never		<input type="checkbox"/> At least 3 times a week <input type="checkbox"/> Once or twice a week <input type="checkbox"/> Seldom or never					
32. Indicate the number of surgeries for your primary condition:	<input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more							
33. How many days ago did this condition begin?	<input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-21 <input type="checkbox"/> 22-90 <input type="checkbox"/> 91-6 mo <input type="checkbox"/> more than 6 mo							

PLEASE CONTINUE ON BACK OF THIS PAGE

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34. I should not do physical activities which (might) make my pain worse:	<input type="checkbox"/> 0 (completely disagree) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Unsure <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 (completely agree)
35. Other health problems may affect my treatment	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Hepatitis or AIDS
<input type="checkbox"/> Angina	<input type="checkbox"/> High Blood Pressure (HBP)
<input type="checkbox"/> Anxiety or Panic Disorders	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Arthritis (rheumatoid / osteoarthritis)	<input type="checkbox"/> Kidney, bladder, prostate, or urination problems
<input type="checkbox"/> Back Pain (neck pain, low back pain, degenerative disc disease (DDD), spinal stenosis)	<input type="checkbox"/> Neurological Disease (Multiple Sclerosis or Parkinson's)
<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Chronic obstructive Pulmonary Disease (COPD), Acquired Respiratory Distress Syndrome (ARDS), or emphysema	<input type="checkbox"/> Other Disorders
<input type="checkbox"/> Congestive Heart Failure (heart disease)	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Depression	<input type="checkbox"/> Previous accidents
<input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)	<input type="checkbox"/> Prior surgery
<input type="checkbox"/> Headaches	<input type="checkbox"/> Prosthesis / Implants
<input type="checkbox"/> Hearing Impairment (hard of hearing, even with hearing aids)	<input type="checkbox"/> Sleep dysfunction
<input type="checkbox"/> Heart Attack (Myocardial Infraction)	<input type="checkbox"/> Stroke or TIA
<input type="checkbox"/> Heart Attack (Myocardial Infraction)	<input type="checkbox"/> Visual Impairment (cataracts, glaucoma, macular degeneration)
36. Height:	Are you having trouble sleeping? <input type="checkbox"/> Yes <input type="checkbox"/> No
37. Weight:	Normal hours of sleep: _____ Current hours of sleep: _____
Do you normally sleep on your <input type="checkbox"/> back <input type="checkbox"/> stomach <input type="checkbox"/> left side <input type="checkbox"/> right side	

AS OF TODAY	Evaluation Date:	Discharge Date:
1. Would you say your health is:	<input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Very Good	<input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Very Good
2. Do you cut down on the amount of time you spend on work:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you accomplish less than you would like on work:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you perform work less carefully:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have there been 2 weeks or more during which you feel/felt sad or blue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have there been 2 years or more when you felt depressed or sad?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you felt depressed or sad much of the time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	All of the time Good bit of time Some of the time None of the time	
8. Are you nervous?	<input type="checkbox"/>	<input type="checkbox"/>
9. Down in the dumps?	<input type="checkbox"/>	<input type="checkbox"/>
10. Feel down-hearted?	<input type="checkbox"/>	<input type="checkbox"/>
11. Feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
	Definitely true Mostly true Mostly false Definitely false	
12. I get sick easily:	<input type="checkbox"/>	<input type="checkbox"/>
13. My health got worse:	<input type="checkbox"/>	<input type="checkbox"/>
	None of the time Some of the time Good bit of time All of the time	
14. I feel full of pep:	<input type="checkbox"/>	<input type="checkbox"/>
15. I am calm and peaceful:	<input type="checkbox"/>	<input type="checkbox"/>
16. I have a lot of energy:	<input type="checkbox"/>	<input type="checkbox"/>
17. I am a happy person:	<input type="checkbox"/>	<input type="checkbox"/>
	Most of the time Some of the time A little of the time None of the time	
18. My health interferes with my social activities:	<input type="checkbox"/>	<input type="checkbox"/>
	All of the time Good bit of time Some of the time None of the time	
19. My feel my health is like anybody:	<input type="checkbox"/>	<input type="checkbox"/>
20. My health is excellent:	<input type="checkbox"/>	<input type="checkbox"/>

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Satisfaction Survey

For your current rehabilitation treatment, how satisfied were you with:	Very Satisfied	Somewhat Satisfied	Neither	Somewhat Dissatisfied	Very Dissatisfied
1. The information your therapist gave you about your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The therapist's inclusion of your input in setting treatment goals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The availability of convenient therapy appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Access to this facility location?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The level of courtesy and respect show to you by the staff at this facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The therapy treatment for your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Overall results of your therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Based on your experience at this facility, you would say to a friend, "I was ..."	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>