



Patient Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address (Florida): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Address (Not Florida): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_

Sex (circle one) Male Female

Marital Status (circle one) Single Married Divorced Separated Widowed

Insurance Company (Primary) \_\_\_\_\_ ID# \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Company (Secondary) \_\_\_\_\_ ID# \_\_\_\_\_ Phone # \_\_\_\_\_

Please fill out the following information if your insurance is not in your name:

Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Are you able to work?(circle) yes no Occupation \_\_\_\_\_ (circle) Full time Part time

Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of injury, surgery or onset of symptoms (mm/dd/yy) please be specific \_\_\_\_\_

Possible cause for injury (fall, car accident, work related): \_\_\_\_\_

If due to car accident or work, did you report the accident? (circle one) Yes No

Please fill out the following information if you were in a motor vehicle accident:

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Case Manager \_\_\_\_\_ Claim # \_\_\_\_\_

Attorney \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Please fill out the following information if you sustained your injury at work:

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Case Manager \_\_\_\_\_ Claim # \_\_\_\_\_

Are you currently receiving any other treatments: \_\_\_\_\_

Are you currently receiving home health services: Yes No If yes answer below

Home health company name \_\_\_\_\_

Phone # \_\_\_\_\_ Contact \_\_\_\_\_

When was your last visit? \_\_\_\_\_ Are they scheduled to return? Yes No

Thank you for your cooperation. If you are unable to keep your scheduled appointments, please notify us within 24 hours before your scheduled appointment time. A \$25 fee will be assessed for missed appointments without a 24 hours notice.

I have read and understand the policy regarding fees and agree to pay any remaining balance. I authorize payment directly to Florida GulfCoast Physical Therapy. I authorize consent to copy and release PT records of treatment, charges, and reports to physicians and other parties, as indicated.

What are your goals for therapy? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_



Name \_\_\_\_\_

Diagnosis / complaint \_\_\_\_\_

Date of injury / onset of symptoms \_\_\_\_\_

Symptoms \_\_\_\_\_

Tests:(circle all that apply)    x-ray    MRI    CT scan    arthrogram    sonogram    EMG    NCV    Bone density

Results: \_\_\_\_\_

Pain description: (circle all that apply)    Sharp    Dull    Achy    Shooting    Stabbing    Stiff    Throbbing

Other: \_\_\_\_\_

Do you experience: (circle all that apply)    Numbness    Tingling    Burning    Weakness    Cramping

Other: \_\_\_\_\_

Please mark the lines below as indicated

Right                      Left                      Left                      Right

Pain at best (0/10 = no pain, 10/10 pain = emergency)

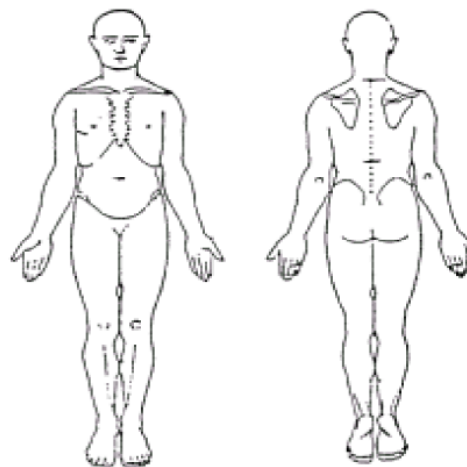
0 \_\_\_\_\_ 5 \_\_\_\_\_ 10 \_\_\_\_\_

Pain at worst (0/10 = no pain, 10/10 pain = emergency)

0 \_\_\_\_\_ 5 \_\_\_\_\_ 10 \_\_\_\_\_

Current pain (0/10 = no pain, 10/10 pain = emergency)

0 \_\_\_\_\_ 5 \_\_\_\_\_ 10 \_\_\_\_\_



Put an 'X' on the diagram above where you feel pain.

Is your pain: (circle)    Constant    Intermittent    At regular intervals

Does your pain: (circle)    prevent sleep    wake you from sleep    feel better after sleep    feel worse after sleep    not influenced by sleep

What increases your symptoms? \_\_\_\_\_

What decreases your symptoms? \_\_\_\_\_

Do you have any of the following: (circle)

Yes No	<b>Heart condition/Heart Attack</b>	Yes No	<b>Stroke</b>	Yes No	<b>Diabetes</b>
Yes No	<b>Asthma</b>	Yes No	<b>High Blood Pressure</b>	Yes No	<b>Low Blood Pressure</b>
Yes No	<b>Anemia</b>	Yes No	<b>Seizures / Epilepsy</b>	Yes No	<b>Severe / Chronic Headaches</b>
Yes No	<b>Arthritis</b>	Yes No	<b>Pacemaker</b>	Yes No	<b>Osteoporosis</b>
Yes No	<b>Kidney Disease</b>	Yes No	<b>Hepatitis / Jaundice</b>	Yes No	<b>Hearing loss</b>
Yes No	<b>Circulatory Problems</b>	Yes No	<b>Recent Weight Gain / Loss</b>	Yes No	<b>Dizziness / Loss of Balance</b>
Yes No	<b>Incontinence</b>	Yes No	<b>Pregnant</b>	Yes No	<b>Cancer</b>

Other: \_\_\_\_\_

During the past 5 years have you been admitted to the hospital or had surgery?(circle)    Yes    No    If Yes explain:

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Have you had any previous orthopedic problems, injuries or surgeries?

Date: \_\_\_\_\_ Diagnosis \_\_\_\_\_    Date: \_\_\_\_\_ Diagnosis \_\_\_\_\_    Date: \_\_\_\_\_ Diagnosis \_\_\_\_\_

Date: \_\_\_\_\_ Diagnosis \_\_\_\_\_    Date: \_\_\_\_\_ Diagnosis \_\_\_\_\_    Date: \_\_\_\_\_ Diagnosis \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ DATE: \_\_\_\_\_

**Description:** This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. Please circle the answers below that best apply.

**1. Please rate your pain level with activity:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

**MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT**

**1. Pain Intensity**

- (0) I can tolerate the pain I have without having to use pain medication.
- (1) The pain is bad, but I can manage without having to take pain medication.
- (2) Pain medication provides me with complete relief from pain.
- (3) Pain medication provides me with moderate relief from pain.
- (4) Pain medication provides me with little relief from pain.
- (5) Pain medication has no effect on my pain.

**2. Personal Care (washing, dressing, etc.)**

- (0) I can take care of myself normally without causing increased pain.
- (1) I can take care of myself normally, but it increases my pain.
- (2) It is painful to take care of myself, and I am slow and careful.
- (3) I need help, but I am able to manage most of my personal care.
- (4) I need help every day in most aspects of my care.
- (5) I do not get dressed, wash with difficulty, and stay in bed.

**3. Lifting**

- (0) I can lift heavy weights without increased pain.
- (1) I can lift heavy weights, but it causes increased pain.
- (2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
- (3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

**4. Walking**

- (0) Pain does not prevent me from walking any distance.
- (1) Pain prevents me from walking more than 1 mile.
- (2) Pain prevents me from walking more than 1/2 mile.
- (3) Pain prevents me from walking more than 1/4 mile.
- (4) I can only walk with crutches or a cane.
- (5) I am in bed most of the time and have to crawl to the toilet.

**5. Sitting**

- (0) I can sit in any chair as long as I like.
- (1) I can only sit in my favorite chair as long as I like.
- (2) Pain prevents me from sitting more than 1 hour.
- (3) Pain prevents me from sitting more than 1/2 hour.
- (4) Pain prevents me from sitting more than 10 minutes.
- (5) Pain prevents me from sitting at all.

**6. Standing**

- (0) I can stand as long as I want without increased pain.
- (1) I can stand as long as I want but, it increases my pain.
- (2) Pain prevents me from standing more than 1 hour.
- (3) Pain prevents me from standing more than 1/2 hour.
- (4) Pain prevents me from standing more than 10 minutes.
- (5) Pain prevents me from standing at all.

**7. Sleeping**

- (0) Pain does not prevent me from sleeping well.
- (1) I can sleep well only by using pain medication.
- (2) Even when I take pain medication, I sleep less than 6 hours.
- (3) Even when I take pain medication, I sleep less than 4 hours.
- (4) Even when I take pain medication, I sleep less than 2 hour
- (5) Pain prevents me from sleeping at all.

**8. Social Life**

- (0) My social life is normal and does not increase my pain.
- (1) My social life is normal, but it increases my level of pain.
- (2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
- (3) Pain prevents me from going out very often.
- (4) Pain has restricted my social life to my home.
- (5) I have hardly any social life because of my pain.

**9. Traveling**

- (0) I can travel anywhere without increased pain.
- (1) I can travel anywhere, but it increases my pain.
- (2) My pain restricts my travel over 2 hours.
- (3) My pain restricts my travel over 1 hour.
- (4) My pain restricts my travel to short necessary journeys under 1/2 hour.
- (5) My pain prevents all travel except for visits to the physician/therapist or hospital.

**10. Employment / Homemaking**

- (0) My normal homemaking/job activities do not cause pain.
- (1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- (2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
- (3) Pain prevents me from doing anything but light duties.
- (4) Pain prevents me from doing even light duties.
- (5) Pain prevents me from performing any job or homemaking chores.

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Therapist Use Only		
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD9 Code: _____

