Florida GulfCoast
Physical Therapy LLC

PATIENT INFORMATION SHEET

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**_____

Florida GulfCoast
Physical Therapy LLC

Phone: 239-948-2222
Fax: 239-948-2225
Web: flgulfcoastpt.com

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

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

0_____5_____10

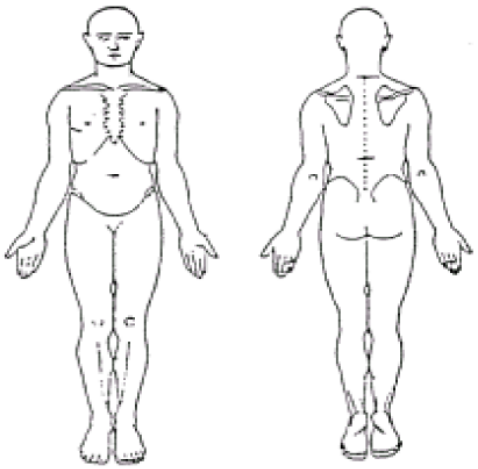
Pain at worst (0/10 = no pain, 10/10 pain = emergency)

0_____**5**_____**10**

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

0_____**5**_____**10**

Right Left Left Right



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

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.
z(2) Pain prevents me from walking more than ½ mile.
(3) Pain prevents me from walking more than ¼ 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 ½ 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 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.

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

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.**

LEFS – INITIAL VISIT

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

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code: _____

Current Medication List

Medication	Dosage	Frequency	How is drug administered?			
			Oral	Transdermal	Suppository	Injection
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
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