PRECISION
ORTHOPEDICS & SPORTS MEDICINE

INITIAL SELF-EVALUATION

Name:_____ **Age:**_____ **Date:**_____

Occupation: _____ **Last day worked (if applicable):**_____

Have you had surgery for this condition?: ☐ **YES** ☐ **NO** **If yes, on what date?**_____

Please take a moment to fill out the following questions as accurately as able. This information will greatly improve my ability to help you with your condition. **Please don't forget to sign at the end.** ***If you need assistance with this form, please contact the front desk.***

PRESENT CONDITION:

A. Please mark your primary complaint:

Loss of: ☐ Function ☐ Motion ☐ Strength

Pain with: ☐Walking ☐ Sleeping ☐ Standing ☐ Sitting ☐ Sports ☐ Reaching ☐ Lifting ☐ Work duties

☐ Other:_____

B. Please explain the condition that brought you to Physical / Occupational Therapy or why your doctor sent you here.

_____

On what date did this occur? If there was no injury, for how long have you had these symptoms?

_____

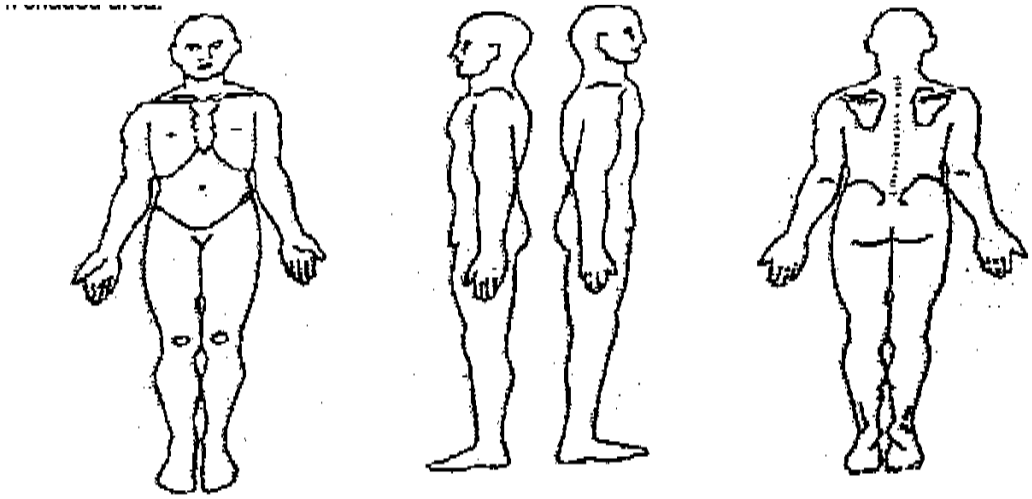
_____

C. List all medications you are taking, including vitamins or herbal supplements: _____

_____

_____

D. Please shade in area or areas where you are experiencing pain/symptoms. Then draw a line from the words below to the shaded area on body where you feel that symptom. Feel free to use more than one description for each shaded area.



☐ Weakness ☐ Stiffness ☐ Radiating ☐ Burning ☐ Severe ☐ Moderate

E. Please list each symptom area above and rate it on the scale provided.
(0 = No pain, 5 = moderate pain, 10 = most severe pain (need to go the emergency room)

SYMPTOMS	SEVERITY
1._____	0 1 2 3 4 5 6 7 8 9 10
2._____	0 1 2 3 4 5 6 7 8 9 10
3._____	0 1 2 3 4 5 6 7 8 9 10

F. Overall your symptoms are: ☐getting better ☐ worsening ☐ staying the same?

G. What makes your symptoms worse? For How Long?

☐ Sitting: How Long?_____ ☐ Standing: How Long?_____ ☐ Bending: Direction _____

☐ Walking: How Long?_____ ☐ Reaching: Direction _____

☐ Other – Please specify:_____

H. What eases your symptoms?

☐Sitting ☐ Standing ☐ Ice ☐Heat ☐ Rest ☐ Elevation

☐ Other: Please specify_____

I. Please circle how often you experience the symptoms:

☐ Constant ☐ Comes & goes ☐ Certain times of day ☐ Certain positions

☐ Other_____

J. How much do your symptoms interfere with your activities?

Activities of Daily Living:

☐ None ☐ Rarely ☐ Often ☐ Most of the time ☐ Always

Extra-curricular:

☐ None ☐ Rarely ☐ Often ☐ Most of the time ☐ Always

K. Are you taking medication for THESE symptoms? YES / NO

If yes, what and how much?_____

L. Have you received any injections for these symptoms? ☐YES ☐NO If yes, on what date(s)?_____

The injection provided: ☐Good relief ☐ Some relief ☐ No relief

M. What tests have been performed? ☐ X-ray ☐ MRI ☐ EMG ☐ CT ☐ Bone scan ☐ Other:_____

What are the test results? _____

N. Do you have any follow up testing scheduled? ☐ YES ☐ NO If yes, when?_____

☐ X-ray ☐ MRI ☐ EMG ☐ CT ☐ Bone scan ☐ Other: _____

O. When is your next scheduled follow up with your doctor who requested this therapy? _____

PAST HISTORY of SIMILAR SYMPTOMS:

A. Have you ever had the same kind of symptoms as you have now? ☐ YES ☐ NO If no, skip to next section.

B. If Yes, when?_____

C. How often do they recur?_____

D. How is this episode different? ☐Severity ☐Irritability ☐Nature ☐Location

E. What made them better before?_____

PAST MEDICAL HISTORY:

A. Any other accidents or injuries for which you saw a doctor? ☐ YES ☐ NO If yes, please list:

_____

B. ANY surgeries? (Heart, abdominal, any bone or joint or ligament or other?) ☐ YES ☐ NO If yes, please list:

_____

C. Other medications or problems diagnosed by a physician (Include Name of MD)? ☐ YES ☐ NO

_____

D. Have you HAD or do you NOW HAVE any of the following:

☐ Arthritis	☐ Osteoporosis
☐ Diabetes	☐ High blood pressure
☐ Blood disorder**	☐ Short of breath
☐ Heart Condition	☐ Infectious disease**
☐ Hernia	☐ Bowel / bladder problems
☐ Seizures	☐ Unexplained weight/energy loss**
☐ Dizziness	☐ Hearing or vision difficulty
☐ Cancer	☐ Emotional problems
☐ Sleeping difficulty	☐ Smoker – packs/day _____
☐ Stroke /blood clot	☐ Currently pregnant
☐ Severe/frequent headaches	☐ Alcohol Use
☐ Pacemaker	☐ Defibrillator ☐ Other**

***please explain/describe:* _____

E. Height:_____ Weight:_____

F. Are you currently under the care of a physician, psychiatrist or other healthcare professional in addition to the one prescribing your Physical / Occupational Therapy? ☐ YES ☐ NO If so, Who?

_____

G. Have you ever had any Physical / Occupational Therapy or other body work prior to this occasion? ☐ YES ☐ NO If yes, please explain

_____

H. Is there anything else you would like me to know about? If so, please explain.

_____

I. What are your expectations to gain through therapy?

☐ Decrease pain ☐ Regain strength ☐ Regain motion ☐Return to specific activity

☐ Improve Function:_____ ☐ Other_____

Thank you for taking the time to tell me about your symptoms. I look forward to discussing your symptoms with you. **Please sign below.**

_____ _____

Patient Signature **Date**

_____ _____

Reviewed / Signed by Therapist: **Date**

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Acknowledgement and Review of Notice of Privacy Practices

_____ I have received and reviewed this facility's Notice of Privacy Practices, which explains how my
Initials private health information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Disclosure of Medical Information

I hereby give permission to Irving Orthopedics & Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following individuals (relatives or close personal friends):

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

____ I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical conditions

Facsimile Authorization

I, the undersigned, authorize IOSM PT Department to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below. I may revoke this authorization by giving IOSM five (5) days written notice. This revocation may be by facsimile transmission; however, a **written copy of the revocation must be mailed to IOSM as well.**

_____

Print Patient Name

_____ _____

Signature of Patient/Guardian Date

_____

Facility Representative Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of review of our Notice of Privacy Practices, but were unable to do so for the following reason:

☐ Patient/Guardian refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ Other (please specify): _____

_____

Facility Representative Signature

PRECISION
ORTHOPEDICS & SPORTS MEDICINE

Physical Therapy Department
Phone (972) 438-3800 / Fax (972) 438-3996

Appointment Policy

Our clinic strives to offer convenient and flexible appointment times for all of our patients. We do our best to accommodate all of our patient's schedules. Please be sure to schedule your future visits at least one week in advance as it will be more difficult to give you the times that you desire. You must stop at our checkout window to schedule these visits or call our office 972-438-3800 and speak with our receptionist. If you discuss scheduling with your therapist during your treatment time, you must confirm this with our checkout receptionist as well.

New Patients: Please give a 48 hour notice for cancellations or rescheduling so that we may accommodate another patient that might need to be worked in. Failure to give proper notice will result in a cancelation fee of $25.00

Cancellations: If you should need to cancel an appointment, please give at last a 24 hour notice so that we may accommodate another patient that might need to be worked in.

Punctuality: Please be on time. If you are more than 30 minutes late, you may be asked to reschedule your appointment. Please contact our office if possible to notify us that you will be late. We try to take our patients back within 5 minutes of their scheduled time.

***No-Shows*:** If you miss your appointment without calling this takes away time that could have been given to another patient in need of care. If you should no show for an appointment a no show fee may apply. If there are three consecutive "no-shows" you will be discharged for non-compliance with your therapy services.

_____

Patient/Guardian Name (Printed) Date

_____

Patient/Guardian Signature Date