



PHYSICAL THERAPY

Medical History

Name: _____ Age: _____ Today's Date: _____

Please complete the following questions to the best of your ability. This will help us develop a treatment plan that will meet your individual needs.

1. Reason for this visit? (please circle one) **Surgery** **Injury** **Other**
If other, please describe: _____

2. Date of Injury/Surgery (or when problem caused you to seek medical attention): _____

3. How did this current problem begin?
(please check one)
 - lifting
 - twisting
 - falling
 - MVA
 - unknown
 - other: _____

4. Are you currently being seen by any of the following?
(check all that apply)
 - Dentist
 - Chiropractor
 - Osteopath
 - Physical Therapist
 - Occupational Therapist
 - Home Health*If you checked a box, describe the reason:* _____

5. What can you no longer do because of your current condition? _____

6. Please mark all the areas where you have seen a decline in your abilities since your most recent injury/surgery (check all that apply):
 - getting in/out of bed getting in/out of chairs walking/balance
 - eating dressing grooming
 - lifting bending other: _____

7. Are you experiencing pain due to your current injury/surgery? **Yes / No**

8. Have you had therapy for this recent injury/surgery? **Yes / No**
If yes, please explain where, when and the outcome of your therapy: _____

9. Are you presently working? **Yes / No**
Occupation? _____
If working, is it light/modified or regular duty? _____

10. Are you: **Left Handed** **Right Handed**

11. Do you use a: **Cane** **Walker** **Other:** _____

12. What type of exercise are you currently doing? _____

13. How (if at all) have your exercise and daily activities changed due to your current condition? _____

14. Do you currently experience any of the following?
- | | | |
|--|--|--|
| <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> GI |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Multi Sclerosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Drug/Alcohol Dependency | |

15. Have you ever had a broken bone or fracture? **Yes / No**
If yes, which body part? _____

16. Do you smoke? **Yes / No**
If yes, number of packs per day? _____

17. Are you pregnant? **Yes / No**

18. What would you like to learn regarding your current condition? _____

19. Do you have any problems with any of the following?
(check all that apply)
- Caring for yourself
 - Obtaining Medications
 - Keeping Appointments
 - Obtaining Meals

MEDICARE PATIENTS: Have you had any Physical, Occupational or Speech Therapy since January 1, 2008? <i>Yes / No</i> If yes, where? : _____

NEBRASKA SPINE CENTER LLP – PHYSICAL THERAPY

CONSENT FOR TREATMENT

Patient's Name: _____ Date: _____

I hereby authorize the therapists at the Nebraska Spine Center LLP – Physical Therapy to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

(Authorized Signature) (Date)

NEBRASKA SPINE CENTER LLP – PHYSICAL THERAPY

13616 California Street, Suite 100

Omaha, NE 68154

Phone 402-496-5556

Dear Patient,

Welcome to physical therapy. We are pleased that you have chosen us for your rehabilitation needs. Our goal is to provide you with the highest quality care in a clean and professional environment. Before you begin your therapy program, an evaluation will be performed to assess your individual needs. The evaluation will take approximately 60 minutes. It is important that you come to your evaluation at least 15 minutes early to complete necessary paperwork.

When you come for your evaluation, you should bring the following information:

1. Therapy prescription from physician
2. Insurance card
3. Co-pay (if applicable)

Appointments:

Our patients are seen by appointment only. After your evaluation, schedule follow up visits at our reception desk. It is critical that you are on time for your appointments. Being late may make it necessary to shorten your therapy session so it does not disrupt other patient's scheduled appointments.

Appropriate Attire:

Please wear clothes suitable and comfortable to perform exercise. This includes shorts, sweats, athletic sweats and shirt. If you have a knee problem it is best to wear shorts so we can work on your knee, as needed.

Cancellations / Reschedule:

Because we provide services by appointment, it is critical that you allow 24 hour notice if you must cancel an appointment. This is a courtesy to the clinical staff as well as to other patients. Habitual cancellations or no shows may lead to discontinuation of services and/or notification to your physician and insurance carrier.

Regular attendance and active participation in your therapy program is necessary for you to get the maximum benefit from our services. It is also important for you to have open communication with your therapist about the therapy being provided and any pain you might be experiencing so that therapy can be adjusted to meet your needs.

If you have any questions regarding our services, please call our office at 402-496-5556.

We look forward to working with you.

Sincerely,

Jane Sinsheimer, PT, MA, cert MDT