CENTRAL OHIO PRIMARY CARE
THE BEST FOR PRIMARY CARE

Physical Therapy

Name: _____ **Age:** _____ **Gender:** _____ **Dominant Hand:** R __ L __

1. Describe the problem for which you seek physical therapy: _____

_____

2. Do you have pain or discomfort? Yes _____ No _____

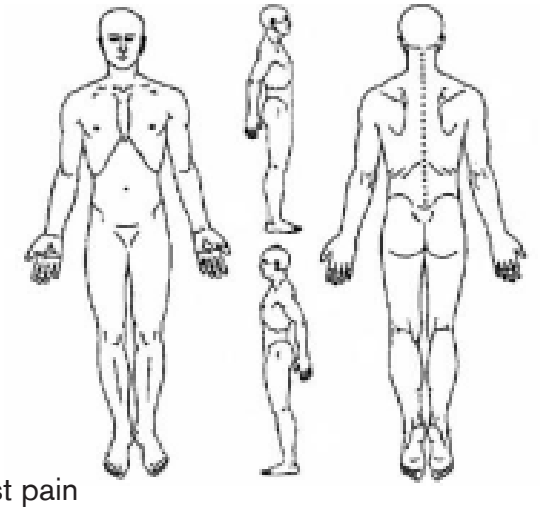
3. Pain is difficult to describe. Circle the words that best describe your symptoms:

Burning Throbbing Aching Stabbing Tingling Shooting Numbing Pressure Dull

4. Nature of Condition (circle one):

Initial Onset (within last 3 months)
Recurrent (multiple episodes of <3 months)
Chronic (Continuous duration >3 months)

Indicate where you have pain or other symptoms



5. Symptoms began on: _____
mm/dd/yyyy

6. How did your symptoms start? _____

_____

7. Average pain intensity (circle one)

Last 24 Hours no pain 1 2 3 4 5 6 7 8 9 10 worst pain

Past Week no pain 1 2 3 4 5 6 7 8 9 10 worst pain

8. How often do you experience your symptoms? (circle one)

1 Constantly (76-100% of the time) 3 Occasionally (26-50% of the time)

2 Frequently (51-75% of the time) 4 Intermittenly (0-25% of the time)

9. How much have your symptoms interfered with your usual daily activities? (circle one)
(including both work outside the home and housework)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

10. How is your condition changing since care began at this facility? (circle one)

0 N/A-This is the initial visit 1 Much Worse 2 Worse 3 A little worse

4 No change 5 A little better 6 Better 7 Much Better

11. In general, would you say your overall health right now is (circle one)**:**

1 Excellent 2 Very Good 3 Good 4 Fair 5 Poor

12. Does movement have any effect on your pain? (circle one)

Makes it better Makes it worse No change

13. Do you have trouble with sleep because of your pain? (circle one)

Trouble falling asleep Awakened from sleep No trouble falling asleep

14. Are you presently a victim of abuse? (circle one)

Yes No No comment

15. Describe how you are taking care of the problem now. _____

_____

16. Describe what makes the problem better. _____

_____

17. Describe what makes the problem worse. _____

_____

18. Please list your goals for physical therapy. What would you like to be able to do when you are finished? Please be as specific as possible.

_____

_____

Patient Signature: _____ **Date:** _____

Reviewed By Physical Therapist: _____

Signature

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Oswestry Low Back Pain Scale

Name: _____

Date: _____

Please rate the severity of your pain by circling a number :

No Pain ⟶ Unbearable pain									
1	2	3	4	5	6	7	8	9	10

Section 1 - Pain Intensity

0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is severe.
5 The pain is severe and does not vary much.

Section 2 - Personal Care (Washing, Dressing, etc.)

0 I would not have to change my way of washing or dressing in order to avoid pain.
1 I do not normally change my way of washing or dressing even though it causes some pain.
2 Washing and dressing increase the pain but I manage not to change my way of doing it.
3 Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4 Because of the pain I am unable to do some washing and dressing without help.
5 Because of the pain I am unable to do any washing and dressing without help.

Section 3 - Lifting

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it gives extra pain.
2 Pain prevents me lifting heavy weights off the floor.
3 Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g., on a table).
4 Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5 I can only lift very light weights at most.

Section 4 - Walking

0 I have no pain on walking.
1 I have some pain on walking but it does not increase with distance.
2 I cannot walk more than 1 mile without increasing pain.
3 I cannot walk more than 1/2 mile without increasing pain.
4 I cannot walk more than 1/4 mile without increasing pain.
5 I cannot walk at all without increasing pain.

Section 5 - Sitting

0 I can sit in any chair as long as I like.
1 I can sit only 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 I avoid sitting because it increases pain immediately.

Section 6 - Standing

0 I can stand as long as I want without pain.
1 I have some pain on standing but it doesn't increase with time.
2 I cannot stand for longer than 1 hour without increasing pain.
3 I cannot stand for longer than 1/2 hour without increasing pain.
4 I cannot stand for longer than 10 minutes without increasing pain.
5 I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

0 I get no pain in bed.
1 I get pain in bed but it does not prevent me from sleeping well.
2 Because of pain my normal nights sleep is reduced by less than one-quarter.
3 Because of pain my normal nights sleep is reduced by less than one-half.
4 Because of pain my normal nights sleep is reduced by less than three-quarters.
5 Pain prevents me from sleeping at all.

Section 8 - Social Life

0 My social life is normal and gives me no pain.
1 My social life is normal but it increases the degree of pain.
2 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3 Pain has restricted my social life and I don't go out very often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of the pain.

Section 9 - Traveling

0 I get no pain when traveling.
1 I get some pain when traveling but none of my usual forms of travel make it any worse.
2 I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3 I get extra pain while traveling which compels to seek alternative forms of travel.
4 Pain restricts me to short necessary journeys under 1/2 hour.
5 Pain restricts all forms of travel.

Section 10 - Changing Degree of Pain

0 My pain is rapidly getting better.
1 My pain fluctuates but is definitely getting better.
2 My pain seems to be getting better but improvement is slow.
3 My pain is neither getting better or worse.
4 My pain is gradually worsening.
5 My pain is rapidly worsening.

Dublin Physical Therapy
614-339-8088
Eastside Physical Therapy
614-865-3142
Northwest Physical Therapy
614-339-8081

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Sports, Spine and Joint Physical Therapy
614-259-0906
Westerville Physical Therapy
614-392-2812

Valued COPC Physical Therapy Patient:

At Central Ohio Primary Care, it is our goal to give you the best care possible. In order to best serve all of our patients, we request the following:

- If you cannot keep your scheduled appointment, please call us at the number above to cancel the appointment at least 24 hours prior to the visit.
- If you miss an appointment, and fail to call to re-schedule or cancel, you may be assessed a No Show/Late Cancelation fee of $50.00 for an initial evaluation or $25.00 for an established follow-up visit.
- If you have 3 cancellations within a consecutive 3 week period, the Physical Therapist will be notified and will determine if your therapy should resume, or be discontinued.
- If you will be more than 10 minutes late, we may ask you to re-schedule your appointment. This will assure that we are giving you the full time you deserve to address all of your needs during treatment.

Thank you for helping us to provide our patients with the most convenient scheduling possible!

I have read this physical therapy policy and agree to the above.

Today's Date: _____

Printed Name: _____

Signature: _____

CENTRAL OHIO PRIMARY CARE
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Patient Name: _____ DOB: _____ Acct. #_____

Agreement of Financial Responsibility

Thank you for choosing ***Central Ohio Primary Care Physicians, Inc.*** (***COPC***) as your health care provider. COPC is committed to providing quality care and service to all of our patients. The following is a statement of COPC's financial policy, which we require that you read and agree to prior to receiving any treatment from COPC.

Payment of your bill is considered part of your treatment. Fees are due and payable when services are rendered. COPC accepts cash, check, credit cards, and pre-approved insurance for which COPC is a contracted provider.

It is your responsibility to know your own insurance benefits, including:

- whether COPC is a contracted provider with your insurance company;
- your covered benefits and any exclusions in your insurance policy; and
- any pre-authorization requirements of your insurance company.

COPC will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information to COPC, including any updates or changes in your insurance coverage. Should you fail to provide this information, you will be financially responsible for the costs of the services rendered by COPC.

If COPC has a contract with your insurance company, COPC will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

If COPC does not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. COPC will provide you with a statement that you can submit to your insurance company for reimbursement.

Proof of insurance and photo ID are required for all patients. COPC will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Some insurance coverage has Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policy stated above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I acknowledge that if my insurance company denies coverage and/or payment for services provided, I will be financially responsible and will pay all such charges due and owing in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient