GENERAL HISTORY

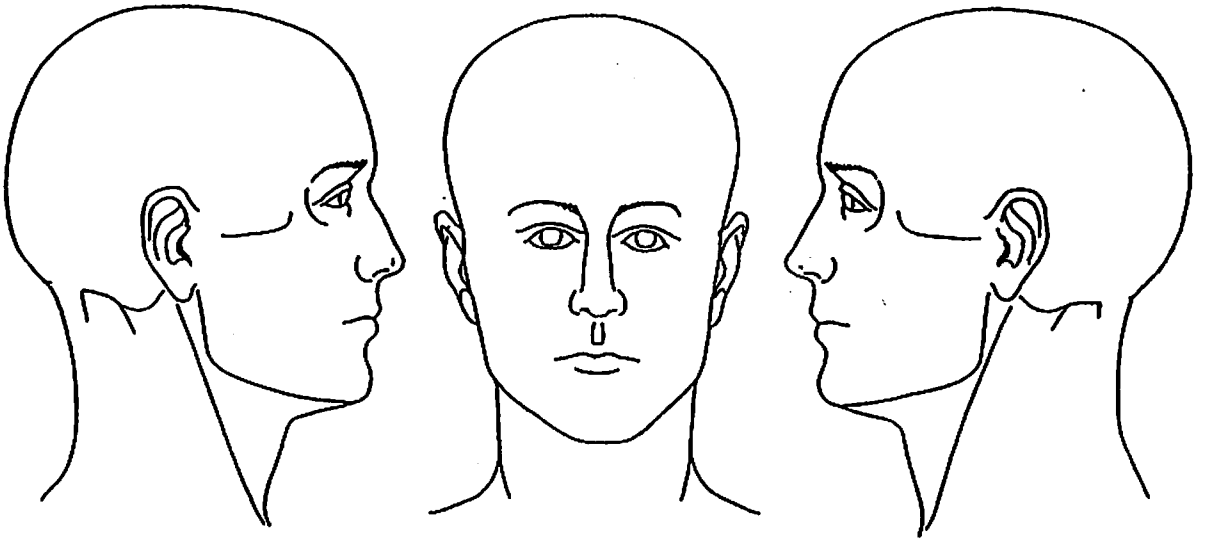
NAME _____ AGE _____ DATE _____

CHIEF COMPLAINT _____

DATE OF INJURY _____ OCCUPATION _____

REFERRING PHYSICIAN _____

FACE DIAGRAM: Please shade in the area of discomfort on the diagram below.



DISCOMFORT SEVERITY SCALE: 0 (no pain) _____ 10 (worst pain)

HISTORY: Please check "yes" or "no"

HEART DISEASE	___	___
RESPIRATORY PROBLEMS	___	___
ALLERGIES	___	___
DIABETES	___	___
CANCER	___	___
OSTEOPOROSIS	___	___
CORTISONE	___	___

SPECIAL TESTS:

X-RAYS	___	___
LABORATORY	___	___
MYELOGRAM	___	___
ARTHROGRAM	___	___
OTHER TEST	___	___

APPROXIMATELY HOW LONG HAVE YOU HAD THIS PROBLEM ? _____.

DOES YOUR JAW JOINT, GRATE _____; CLICK _____; POP _____; SNAP _____; OR LOCK _____.

WHICH SIDE ? RIGHT _____ LEFT _____ BOTH _____.

DO YOU HAVE HEADACHES ? YES ___ NO ___. HOW OFTEN ? DAILY ___; SEVERAL TIMES A WEEK ___.

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT ? YES/NO WHEN: _____.

LIST RELATED SURGERIES & DATES: _____

_____.

HAVE YOU EVER WORN BRACES ON YOUR TEETH ? YES ___ NO ___ WHEN: _____.

HAVE YOU EVER WORN A SPLINT IN YOUR MOUTH ? YES ___ NO ___ WHEN: _____.

WHY: _____.

HAVE YOU HAD ANY SIMILAR PROBLEMS IN THE PAST ? IF SO, PLEASE EXPLAIN: _____

_____.

ARE YOU NOW ON ANY MEDICATION FOR THIS PROBLEM OR ANY OTHER PROBLEM ? _____

_____

PROBLEMS POSSIBLY PERTINENT TO PRESENT CONDITION: (Please Check)

	YES	NO
INJURY	___	___
VIRUS OR FLU JUST PRIOR	___	___
OVER TIRED JUST PRIOR	___	___
IMMOBILIZATION	___	___
UNUSUAL ACTIVITY	___	___

WHAT IS YOUR GENERAL LEVEL OF ACTIVITY ? (Please Circle)

Inactive Mildly Active
Moderately Active Very Active

HAS YOUR LEVEL OF ACTIVITY CHANGED ? _____.

IS YOUR GENERAL LEVEL OF STRESS OR ANXIETY: mild; moderate; severe

HAS YOUR LEVEL OF STRESS CHANGED ? _____.

WHEN DID THE PAIN BEGIN ? (date) _____.

WAS THE PAIN SUDDEN ___, GRADUAL ___, OTHER _____?

IS YOUR PROBLEM GETTING WORSE ___, BETTER ___, OR NOT CHANGING ___ ?

WHEN THE PROBLEM BEGAN, WAS YOUR DISCOMFORT IN EXACTLY THE SAME LOCATION AS YOU HAVE IT NOW ?

_____

IS THE PAIN CONSTANT OR INTERMITTENT ? _____.

DOES YOUR PAIN BEGIN IN THE MORNING: AS THE DAY PROGRESSES; OR AT BEDTIME ? _____.

WHAT AGGRAVATES YOUR PROBLEM ? _____.

WHAT RELIEVES YOUR PROBLEM ? _____.

DOES YOUR DISCOMFORT EVER AWAKE YOU AT NIGHT ? _____.

IS IT HARD FOR YOU TO GET BACK TO SLEEP AFTER YOU ARE AWAKEN ? IF SO, HOW LONG ? _____

_____

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

ANY SIGNIFICANT CHANGES IN WEIGHT LATELY ? _____

ANY CHANGES IN YOUR APPETITE LATELY ? _____

ANY CHANGES IN BOWEL OR BLADDER FUNCTION LATELY ? _____

ANY FEELING OF BEING OVERTIRED LATELY ? _____

ANY SHORTNESS OF BREATH ? _____

ANY GENERAL WEAKNESS, NAUSEA, DIZZINESS OR FEELING FAINT ? _____

SPECIFIC WEAKNESS OR LACK OF COORDINATION OR UNSTEADINESS ? _____

ANY DISCOMFORT ON EXERTION ? _____

ANY UNUSUAL DISCOLORATION OF SKIN ? _____

ANY SENSITIVITY TO COLD ? _____

IS THERE ANYTHING ELSE PERTINENT TO YOUR PROBLEM THAT WE HAVE NOT DISCUSSED ?

_____

_____

_____

PATIENT'S GOALS: (1)

(2)

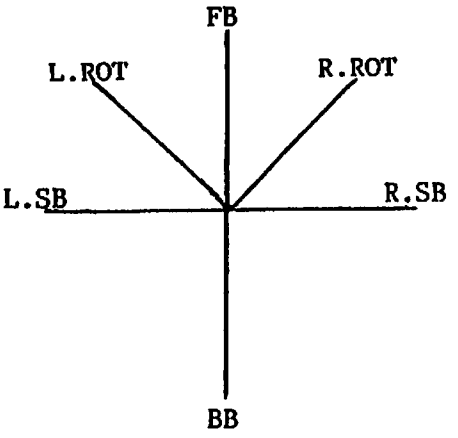
(3)

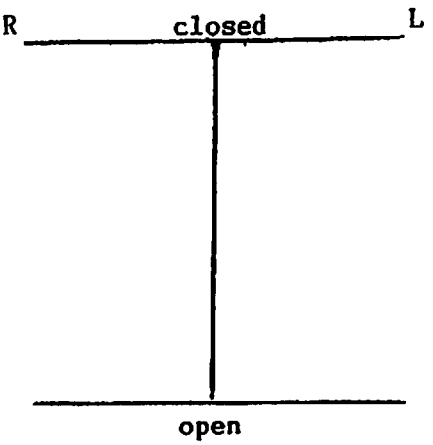
THERAPIST COMMENTS AND NOTES:

OBJECTIVE EVALUATION FORM (THERAPIST USE ONLY)

OBSERVATION & INSPECTION:

POSTURE:





ACTIVE RANGE OF MOTION:

PALPATION:

	LEFT	RIGHT
UPPER TRAPEZIUS		
BODY	____	____
OCCIPUT	____	____
LEVATOR SCAPULAE	____	____
SUBOCCIPITAL	____	____
TEMPORALIS	____	____
MASSETER	____	____
SCM	____	____
TEMPORALIS TENDON	____	____
LATERAL PTERYGOID	____	____

NEUROLOGY:

SENSATION _____

REFLEXES _____

STRENGTH (MMT) _____

PROM: _____

JOINT NOISES: _____

ASSESSMENT: _____

TREATMENT: _____

GOALS: (1)
(2)
(3)
(4)

PLAN: _____

_____

EXERCISES:

PATIENT DEMOGRAPHICS FORM

Last Name: _____ **First:** _____ **Middle:** _____ **DOB:** _____

Social Security#: _____ **Sex:** _____ **Marital Status:** _____

Parent/Legal Guardian Name (if Child is under 18 years old): _____

Address: _____

_____

Home Ph: _____ **Cell Ph:** _____ **Work Ph:** _____

Email Address: _____

Spouse Name: _____ Spouse Phone: _____

Referring Physician: _____ **PCP/Family Physician:** _____

List Current Medications, Drug Sensitivities, and/or Allergies:

_____

_____

IN CASE OF EMERGENCY (PERSON NOT RESIDING WITH PATIENT):

Name: _____ PH: _____ Relationship To Patient: _____

HEALTH INSURANCE: Subscriber Name & DOB (if not yourself): _____

****

AUTO INFORMATION and/or WORKER's COMPENSATION INFORMATION:

Date of Accident: _____ State of Accident: _____ Date You First Sought Treatment: _____

Auto: _____ Work Related: _____ Other (explain): _____

Claims Adjuster Name and Number: _____

PAYMENT and AUTHORIZATION INFORMATION: *Your insurance company will be billed for covered services, and any unpaid balance will be the responsible party signing this form. Parents and guardian (s) are responsible with regards to a minor. The balance of the account will be due and payable if the insurance company has not paid within 45 days of if Worker's Compensation has not paid within 60 days. I hereby authorize Orthopedic Physical Therapy, Inc to release medical information to the insurance company (ies). Also, by my signature and copies thereof, I authorize payment directly to Orthopedic Physical Therapy, Inc of benefits otherwise payable to me. I understand I am financially responsible for charges not covered by this authorization. If my account is turned over to an attorney or agency for collection, I will be responsible for all attorney fees which are usually 33% of the unpaid balance.*

Patient/Legal Guardian Signature: _____ Date: _____

Jan 2023

ORTHOPEDIC PHYSICAL THERAPY, INC.
2000 BREMO RD., SUITE 202, RICHMOND, VA 23226
Ph: 804-285-0148
www.orthopedicptinc.com

INSURANCE
You are responsible to know the details of your insurance benefits, i.e. requirements such as pre-certification or authorization, either from referring physician or primary care physician. Within 48 hours of your first visit, your insurance coverage will be verified. After verification of your coverage has been made, the receptionist will discuss your co-payment and or co-insurance amount due at each visit. **COPAYS** are required before starting treatment. **Regardless of your situation, you are ultimately responsible for payment of your bill. Payments may be made by check, credit card or cash.**

CANCELLATIONS
Cancellation of appointments must be made 24 hours before scheduled appointments. Unless there are unusual circumstances, a cancellation fee of $125.00 will be charged. Payment for this fee will be collected from the patient on their next visit. If you miss an appointment without contacting Orthopedic Physical Therapy to cancel, emergencies notwithstanding, a missed appointment fee of **$125.00** will be charged. If this occurs again, the patient will be charged and may be taken off our schedule and placed on a waiting list. **All appointments and cancellations must be made by phone or in person**

LITIGATION ACCOUNTS WITH ATTORNEYS
Orthopedic Physical Therapy **WILL NOT HOLD LITIGATION ACCOUNTS FOR SETTLEMENT.** You must make arrangements with the Office Manager for payment of these accounts.

COPIES OF RECORDS
All requests for copies must be accompanied by a signed release. Upon receipt of copies, payment for said copies are due in full. A fee sheet is available.

PURCHASING SUPPLIES
When purchasing a supply from Orthopedic Physical Therapy, payment must be made at the front desk when picking up the supply. The patient will receive a receipt that can be used for insurance purposes. Orthopedic Physical Therapy does not file claims with insurance companies for supplies. Payment for custom orders is required at the time order is placed.

NON-COVERED PROCEDURES
Services not covered by your insurance company (i.e. intramuscular stimulation **(dry needling)** etc.) are your responsibility. If your therapist suggests one of these procedures, the fee will be your responsibility. Please sign the waiver form and make your payment prior to treatment.

DIRECT ACCESS PATIENT ATTESTATION AND MEDICAL RELEASE FORM

PATIENT INFORMATION

Date

Name (Full Legal Name) ( ) Primary Phone Number

Street address, City, ST, ZIP Code ( ) Alternate Phone Number

Email address ( ) Alternate Phone Number

Reason why you are seeking physical therapy care:

CURRENT CARE AND ATTESTATION

Please check one below:

☐ **I AM NOT** under the care of a licensed health practitioner for the symptoms listed on this form and I wish to seek physical therapy care at this time. (Licensed health practitioner includes a Doctor of Medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)

I understand that the current course of physical therapy care will last no more than 60 consecutive days, and that additional physical therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional physical therapy services beyond this 60-day period, I will be required to obtain a referral from a licensed health care practitioner.

☐ **I AM** under the care of a licensed health practitioner for the symptoms listed on this form and wish to seek physical therapy care at this time. (Licensed health practitioner includes a Doctor of Medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)

PRACTITIONER INFORMATION:

Practitioner Name Office Number

Street address, City, ST, ZIP Code Fax Number

I understand that the current course of physical therapy care will last no more than 60 consecutive days, and that additional physical therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional physical therapy services beyond this 60-day period, I will be required to obtain a referral from the licensed health care practitioner named above.

I understand that the practitioner named above will be provided a copy of my initial evaluation and patient history within 14 days. ***I hereby consent to the release of my personal health and treatment records to the practitioner named above.***

Patient Signature **Date**

For Administrative Use Only - Expiration Date:

Form 7/1/2021

Name: _____

Date: _____

JAW FUNCTIONAL LIMITATION SCALE

For each of the items below, please indicate the level of limitation **during the last month.** If the activity has been completely avoided because it is too difficult, then circle '10'. If you avoid an activity for reasons other than pain or difficulty, then leave the item blank.

		No Limitation										Severe Limitation
1	Chew tough food	0	1	2	3	4	5	6	7	8	9	10
2	Chew hard bread	0	1	2	3	4	5	6	7	8	9	10
3	Chew chicken (for example, prepared in oven)	0	1	2	3	4	5	6	7	8	9	10
4	Chew crackers	0	1	2	3	4	5	6	7	8	9	10
5	Chew soft food (for example, macaroni, canned or soft fruits, cooked vegetables, fish)	0	1	2	3	4	5	6	7	8	9	10
6	Eat soft food requiring no chewing (for pudding, pureed food)	0	1	2	3	4	5	6	7	8	9	10
7	Open wide enough to bite from a whole apple	0	1	2	3	4	5	6	7	8	9	10
8	Open wide enough to bite into a sandwich	0	1	2	3	4	5	6	7	8	9	10
9	Open wide enough to talk	0	1	2	3	4	5	6	7	8	9	10
10	Open wide enough to drink from a cup	0	1	2	3	4	5	6	7	8	9	10
11	Swallow	0	1	2	3	4	5	6	7	8	9	10
12	Yawn	0	1	2	3	4	5	6	7	8	9	10
13	Talk	0	1	2	3	4	5	6	7	8	9	10
14	Sing	0	1	2	3	4	5	6	7	8	9	10
15	Putting on a happy face	0	1	2	3	4	5	6	7	8	9	10
16	Putting on an angry face	0	1	2	3	4	5	6	7	8	9	10
17	Frown	0	1	2	3	4	5	6	7	8	9	10
18	Kiss	0	1	2	3	4	5	6	7	8	9	10
19	Smile	0	1	2	3	4	5	6	7	8	9	10
20	Laugh	0	1	2	3	4	5	6	7	8	9	10

No Pain At All — Pain As Bad As It Could Be

0 _____ 10

The Oral Behavior Checklist

How often do you do each of the following activities, based on **the last month**? If the frequency of the activity varies, choose the higher option. Please place a (√) response for each item and do not skip any items.

	Activities During Sleep	None of the time	< 1 Night /Month	1-3 Nights /Month	1-3 Nights /Week	4-7 Nights/ Week
1	Clench or grind teeth **when asleep**, based on any information you may have	☐	☐	☐	☐	☐
2	Sleep in a position that puts pressure on the jaw (for example, on stomach, on the side)	☐	☐	☐	☐	☐
	Activities During Waking Hours	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
3	Grind teeth together **during waking hours**	☐	☐	☐	☐	☐
4	Clench teeth together **during waking hours**	☐	☐	☐	☐	☐
5	Press, touch, or hold teeth together other than while eating (that is, contact between upper and lower teeth)	☐	☐	☐	☐	☐
6	Hold, tighten, or tense muscles without clenching or bringing teeth together	☐	☐	☐	☐	☐
7	Hold or jut jaw forward or to the side	☐	☐	☐	☐	☐
8	Press tongue forcibly against teeth	☐	☐	☐	☐	☐
9	Place tongue between teeth	☐	☐	☐	☐	☐
10	Bite, chew, or play with your tongue, cheeks or lips	☐	☐	☐	☐	☐
11	Hold jaw in rigid or tense position, such as to brace or protect the jaw	☐	☐	☐	☐	☐
12	Hold between the teeth or bite objects such as hair, pipe, pencil, pens, fingers, fingernails, etc	☐	☐	☐	☐	☐
13	Use chewing gum	☐	☐	☐	☐	☐
14	Play musical instrument that involves use of mouth or jaw (for example, woodwind, brass, string instruments)	☐	☐	☐	☐	☐
15	Lean with your hand on the jaw, such as cupping or resting the chin in the hand	☐	☐	☐	☐	☐
16	Chew food on one side only	☐	☐	☐	☐	☐
17	Eating between meals (that is, food that requires chewing)	☐	☐	☐	☐	☐
18	Sustained talking (for example, teaching, sales, customer service)	☐	☐	☐	☐	☐
19	Singing	☐	☐	☐	☐	☐
20	Yawning	☐	☐	☐	☐	☐
21	Hold telephone between your head and shoulders	☐	☐	☐	☐	☐

Graded Chronic Pain Scale

1. How would you rate your facial pain on a 0 to 10 scale AT THE PRESENT TIME, that is right now, where 0 is "no pain" and 10 is "pain as bad as could be". *(Circle number)*

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as could be

2. In the PAST SIX MONTHS, how intense was your WORST facial pain? *(Circle number)*

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as could be

3. In the PAST SIX MONTHS, on the AVERAGE, how intense was your facial pain? (That is, your usual pain at times you were experiencing pain.) *(Circle number)*

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as could be

4. About how many days in the LAST SIX MONTHS have you been kept from your usual activities (work, school, housework) because of facial pain? (EVERY DAY = 180)

			DAYS

5. In the PAST SIX MONTHS, how much has facial pain interfered with your daily activities rated on a scale from 0 to 10, where 0 is "No interference" and 10 is "Unable to carry on any activities"? *(Circle number)*

0	1	2	3	4	5	6	7	8	9	10
No interference										Unable to carry on any activities

6. In the PAST SIX MONTHS, how much has facial pain interfered with your ability to take part in recreational, social, and family activities? *(Circle number)*

0	1	2	3	4	5	6	7	8	9	10
No interference										Unable to carry on any activities

7. In the PAST SIX MONTHS, how much has facial pain interfered with your ability to work (including housework)? *(Circle number)*

0	1	2	3	4	5	6	7	8	9	10
No interference										Unable to carry on any activities

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self -care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 5 – HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 – SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my care at all because of neck pain.

SECTION 9 – READING

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

SECTION 10 – RECREATION

- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ DATE _____

SCORE _____ [50] BENCHMARK -5 = _____