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: _____

MEDICAL SERVICES AGREEMENT

I hereby authorize Orthopedic Physical Therapy, Inc. to render medical services to **me**/*my minor child* named _____ and to release any information regarding my medical history, diagnosis, and treatment of me (or child) to my insurance company regarding my claim. I understand that I am financially responsible for all the charges arising for the treatment of the above-named patient. If this contract is referred to an attorney for collection, I agree to pay all attorney fees and court costs incurred. There will be a $25.00 charge for checks returned due to insufficient funds. I hereby consent to any medical treatment and evaluative procedures as the licensed physical therapist considers being necessary or advisable. I understand this may include, but not limited to orthopedic evaluation, modalities or manual treatment. I also hereby consent to have my medical records sent to the following:

PCP: _____ **Referring MD:** _____

Other Entity: _____ _____

Signature of Patient or Representative: _____ **Date:** _____

Acknowledgment of Privacy Practices Notification

Our Notice of Privacy Practices tells you how our practice may use and disclose medical information about you. From time to time, the terms of our notice may change. If we change our notice, you may ask for a revised copy. I _____ (insert name of patient or legal guardian) have been given a copy of the Notice of Privacy Practices as provided by Orthopedic Physical Therapy, Inc. I understand that I may ask questions about any information contained in the Notice of Privacy Practices, and I also understand I may request a copy for my records.

Patient Signature: _____ **Date:** _____

Authorized Representative of Patient or Legal Guardian: _____

Relationship to Patient: _____ **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 07/01/2021

Initial Evaluation (Spine & Scoliosis Specific)

Patient Name:

Date of Birth:

Diagnosis:

Date of Evaluation:

Referring Physician:

History of Presentation:

Chief Complaint:

Patient's Goal(s):

PREVIOUS PHYSICAL THERAPY OR OTHER INTERVENTIONS

- o Physiotherapy (when/what/outcome?)
- o Acupuncture
- o Chiropractic
- o Massage Therapy
- o Personal Training
- o Other_____

MD FOLLOW-UP DATE?

- O Yes
- O None at this time

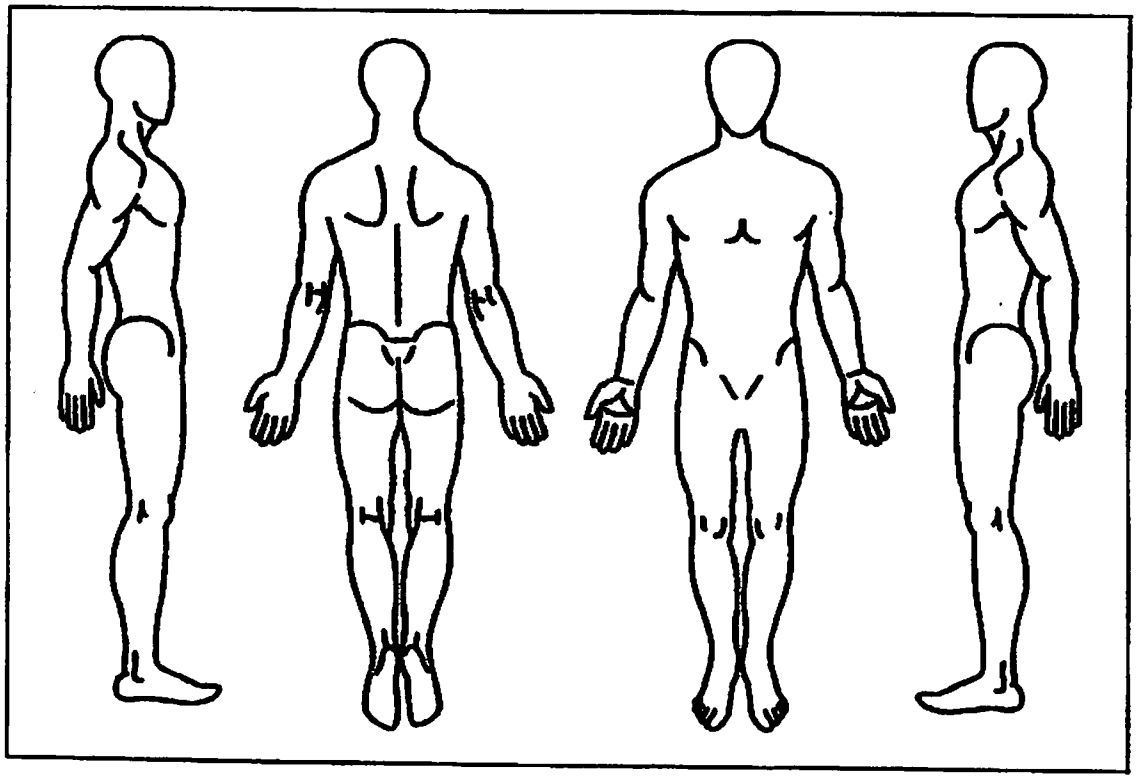
Onset Date or Date Diagnosed:

Primary Care MD or Pediatrician:

PAIN AND/OR NUMBNESS?

O Yes

O No (if none, skip pain section)



Since how long?

O < 1 week O 1-3 mos O 3-6 m O 6-12 mo O > 1 year

Description of Pain

O Constant O Localized O Dull O Stabbing O Achy O Other

O Intermittent O Radiating O Sharp O Throbbing O Spasm _____

Pain Improvement/Change?

O same O better O worse O unsure

Alleviating Factors:

Aggravating Factors:

HISTORY OF BRACING

O Yes O No O Pending O N/A

O Does not have, but would benefit from consult with orthotist

COMPLIANCE WITH BRACING (SUBJECTIVE PER PATIENT):

O Poor O Fair O Excellent O Not Applicable

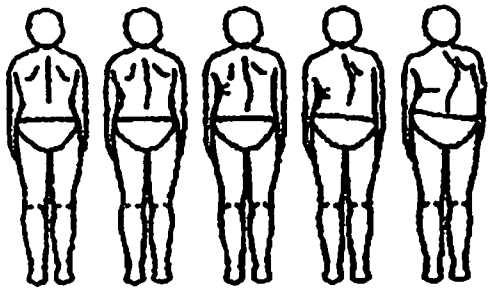
AGE/YEAR START OF MENARCHE (FEMALES):

PRIOR FUNCTIONAL LEVEL:

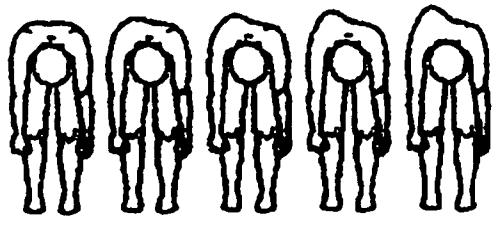
CURRENT FUNCTIONAL LIMITATIONS:

CURRENT RECREATIONAL ACTIVITIES:

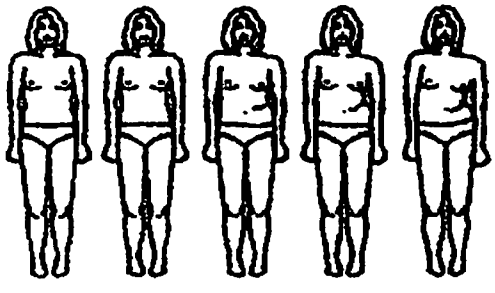
TAPS (Trunk Appearance Perception Scale):



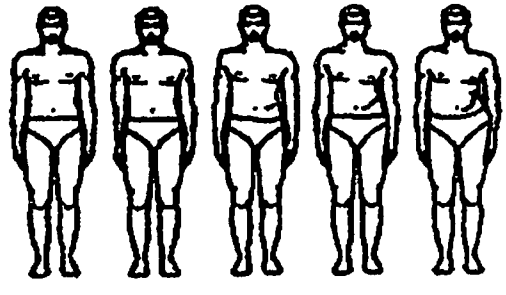
SET 1



SET 2



SET 3 (FEMALES)



SET 3 (MALES)

FOR PHYSICAL THERAPIST USE ONLY

RADIOLOGICAL EVALUATION & X-RAYS

O Yes O No O Pending O See Attached

PATIENT REPORTED COBB ANGLE(S): _____

RISSER (PATIENT REPORT)

O 1 O 2 O 3 O 4 O 5

STANDING HEIGHT: _____

WINGSPAN: _____

SEATED HEIGHT: _____

Clinical Frontal Plane, 3D Postural Observation

Clinical Frontal Plane Posture Observation, Scoliosis Specific:

Thoracic Prominence	Left	Right	None
Lumbar Prominence	Left	Right	None
Pelvis Prominence	Left	Right	None
Trunk Imbalance	Left	Right	None

3D POSTURAL DESCRIPTION

O Forward Head
O Right Shoulder IR
O Left Shoulder IR
O Right Shoulder ER
O Left Shoulder ER
O Right Shoulder Elevation
O Left Shoulder Elevation
O Hyperkyphosis
O Hyperlordosis
O Pectus Excavatum
O Right Rib Flare
O Left Rib Flare
O Anterior Pelvic Tilt
O Posterior Pelvic Tilt
O Neutral Pelvis
O Post Wt Shift/ - Trunk Inclin
O Ant Wt Shift/ + Trunk Inclin
O Genu Recurvatum
O Genu Valgum
O Genu Varum
O Collapsed Arches

FOR PHYSICAL THERAPIST USE ONLY

ADAM'S FORWARD BEND TEST

O Positive O Negative

SPINOUS PROCESSES RECTILINEAR?

O Yes O No

MODIFIED ADAM'S FB TEST

O Positive O Negative

EVIDENCE OF LEG LENGTH DISCREPANCY

O Yes O No O Possible - need more information to determine

ATR (ANGLE OF TRUNK ROTATION) MEASUREMENT (IN DEGREES)

Standing: Cervical _____ Seated: Cervical _____
Thoracic _____ Thoracic _____
Lumbar _____ Lumbar _____

SAGITTAL PLANE MEASUREMENT

Thoracic: _____

Lumbar: _____

INFERIOR ANGLE OF SCAPULA, DISTANCE (IN CM) FROM PLUMB LINE

Right: _____

Left: _____

SAGITTAL PLANE: C7 DISTANCE FROM WALL: _____ CM

RADIOGRAPH/X-RAY ANALYSIS

TRANSITIONAL POINT RELATIVE TO CSL

O Right O Left O Balanced O Not Available

T1 RELATIVE TO CSL

O Right O Left O Balanced O Not Available

FOR PHYSICAL THERAPIST USE ONLY

COUNTER TILT

O Yes O No O Image Unclear/Not Available

D MODIFIER (UEV TILTED DOWN TOWARDS THORACIC CONVEX SIDE)

O Yes O No O Image Unclear/Not Available

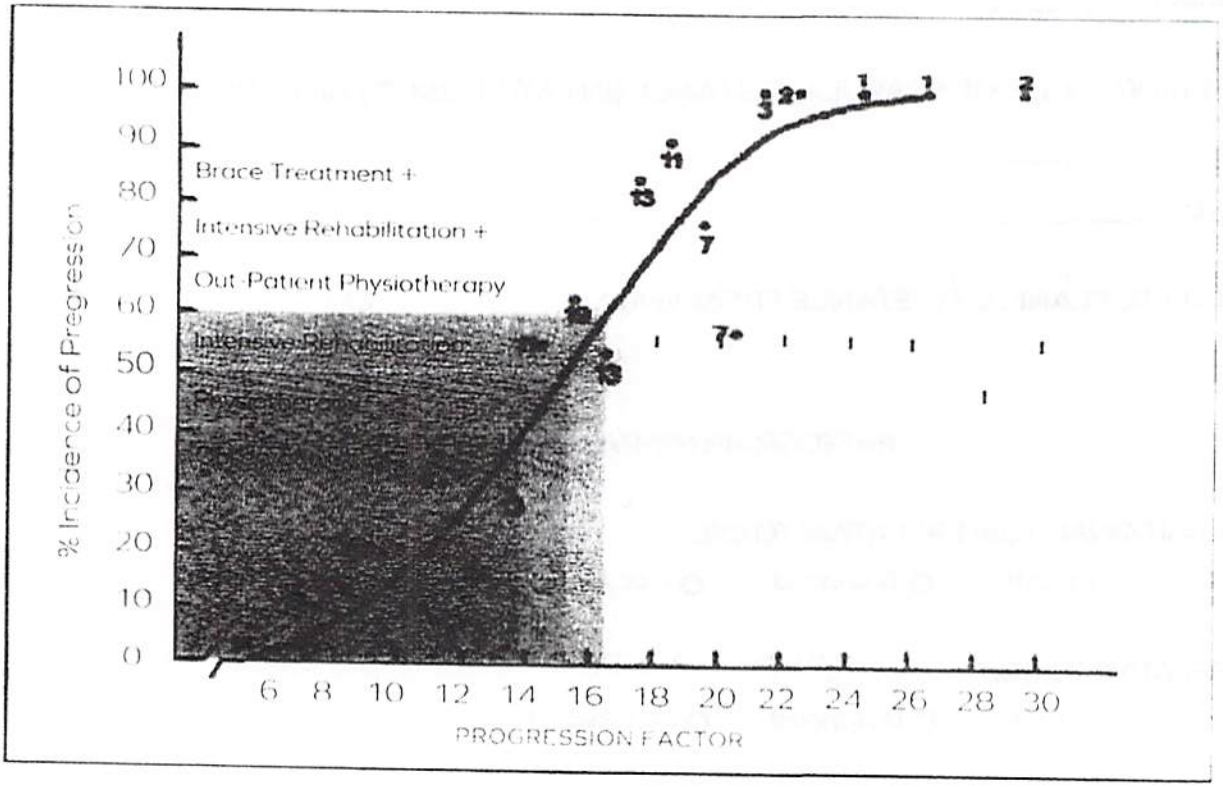
PSSE CURVE CLASSIFICATION:

O 3CR	O N3N4/Balanced w/Lumbar	O Single Right Thoraco-Lumbar
O 3CL	O N3N4/Balanced w/o Lumbar	O Single Left Thoraco-Lumbar
O 4CR	O Single Right Lumbar	O Primary Hyperkyphosis/Scheurmann's
O 4CL	O Single Left Lumbar	O Neuromuscular Scoliosis

Risk of Curve Progression [Cobb-3x Risser/ Age]

O Low O Moderate O High O N/A

Lonstein Risk for Curve Progression and SOSORT Treatment Guidelines
(Lonstein Risk of Curve Progression and SOSORT Treatment Guidelines (2005)



FOR PHYSICAL THERAPIST USE ONLY

BEIGHTON SCORE TO ASSESS FOR JOINT HYPERMOBILITY

Task	Yes (1pt ea)	No (0 pts)
Palms on Ground from Standing with Straight Legs		
Each Elbow that Bends Backwards		
Each Knee that Bends Backwards		
Each Thumb that Touches Forearm when bent back		
Each little finger that Bends Back > 90 degrees		

** If score is ≥ 4, strong positive likelihood for joint hypermobility. 9 points max score.

INCENTIVE SPIROMETER TESTING: _____ _____ _____
Trial 1 Trial 2 Trial 3

RIB EXPANSION MEASUREMENT

Difference between inspiration & expiration: _____ (cm)

- Positive (+) Chest Expansion Test when measurement difference is <2.5 cm (1 inch)
  When positive, this finding indicates decreased costovertebral joint motion
  Normal range between inhale and exhale is 5.8 - 7.6 cm (1.5 - 3 inches)
  Abnormal range for males is < 2.5 cm (1 in), and females is < 1.9 cm (0.75 in)

RESPIRATORY VOLUME

Inhale Length (seconds) _____

Exhale Length (seconds) _____

BREATHING OBSERVATION

O Normal O Shallow O 1° Mouth Breather O Rib Flare R/L/B O Paradoxical/Reverse

O 1° Upper Chest w/Shoulder Elevation O Diaphragmatic Distention

O Limited Rib Cage Excursion: _____

PALPATION: _____

LEG LENGTH (ASIS TO MEDIAL MALLEOLUS)

Right _____ cm

Left _____ cm

FOR PHYSICAL THERAPIST USE ONLY

AROM: WFL AND PAINFREE EXCEPT AS NOTED BELOW:

- o Cervical
- o Shoulder
- o SICK Scapula/Scapular Dyskinesia
- o Thoracic Spine Rotation
- o Lumbar Spine
- o Hip Extension
- o Hip Flexion
- o Hip IR/ER
- o Hip Ab/Adduction
- o Knee
- o Ankle
- o Other

(check only those areas which tested)

- o Not Tested at this time
- o Deep Neck Flexors (C2)
- o Scapular Elevation (C4)
- o Shoulder Flexion
- o Shoulder Abduction
- o Shoulder ER (C5)
- o Shoulder IR
- o Mid Traps
- o Lower Traps
- o Elbow Flexion (C5)
- o Wrist Extn (C6)
- o Elbow Extn & Wrist Flxn (C7)
- o Finger Abduction (T1)
- o Upper abdominals

FOR PHYSICAL THERAPIST USE ONLY

LE MANUAL MUSCLE STRENGTH TESTING & MYOTOMES

(check only those areas which tested)

- o Not Tested at this time
- o Lower Abdominals
- o Glute Med (L1/L2)
- o Hip Flexion (L1/L2)
- o Knee Extension (L3)
- o Ankle DF (L4)
- o Great Toe Extn (L5)
- o Ankle PF / Gastroc/Soleus (S1)
- o Ankle Eversion/Peroneals (S1)
- o Hip Extn/Glute Max (S1)
- o Knee Flxn/Hamstrings (S2)
- o Able to walk on heels?
- o Able to walk on toes without heels dropping?

SINGLE LEG STANCE (MEASURED IN SECONDS)

Right

Left

Comments:

GAIT:

- O Normal, No Dysfxn Noted
- O Decreased Hip Extension
- O Asymmetric or Limited Pelvic Rotation
- O Decreased Step Length
- O Decreased Cadence
- O Decreased Push Off
- O Decreased Foot Clearance
- O Decreased Knee Extension
- O Foot Slap
- O Decreased Thoracic Rotation
- O Lack of Reciprocal Arm Swing

FOR PHYSICAL THERAPIST USE ONLY

PROBLEM LIST

- O Pain
- O Muscle weakness
- O Muscle tightness
- O Decreased Functional ROM
- O Postural Imbalance
- O Decreased Independence w/ ADLs
- O Limited Breath Capacity/Shallow Breath
- O Dysfunctional Breathing Pattern
- O ↓ Knowledge base on self care/ symptom management
- O Need for bracing consult
- O Falls risk
- O Inefficient and/or Limited Gait
- O Other

PATIENT SHOULD BENEFIT FROM SKILLED PHYSIOTHERAPY INCLUDING:

- O 3D Postural Balance
- O _____
- O _____
- O _____
- O _____
- O _____

TREATMENT TODAY INCLUDED:

- O Education on curve pattern/pathomechanics, movement precautions, contraindications
- O Educate patient and/or family on patient's specific 3D postural autocorrections
- O Initiation of HEP
- O Modalities for pain management
- O Educate patient and/or family on bracing resources
- O _____

POTENTIAL EXTRINSIC OBSTACLES TO SUCCESSFUL TREATMENT:

- O None Currently Identified
- O Communication/Language Barriers
- O School/Work/Professional Obligations
- O Limited Insurance Benefits
- O Transportation
- O Financial

Patient/family demo and verbalized understanding of all educational information presented today, and verbally agreed to the plan of care:

O Yes O No

COVID-19 HEALTH INFORMATION & INFORMED CONSENT

Name: _____

Please take the time to understand and fill out this form carefully and accurately. Shou any of this information change at a future appointment please let us know before the scheduled time.

Health questions

1. Have you had a fever in the last 24 hours of 100 F or above? Yes__ No__
2. Do you now, or have you recently had, any of the following: Loss of taste or smel chills, sore throat, cough, muscle aches, shortness of breath, diarrhea)? Yes__ Nc
3. Have you been in contact with anyone in the last 14 days who has been diagnose with COVID-19 or has coronavirus-type symptoms? Yes__ No__
4. Have you traveled outside of the state in the last two weeks? Yes__ No__
   Location: _____
5. Have you been tested for COVID-19 in the past 14 days? Yes__ No__
   Result: Negative__ Positive__

Assumption of Risk and Waiver of Liability Relating to COVID-19

COVID-19 has been declared a worldwide pandemic by the World Health Organization COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. Orthopedic Physical Therapy, Inc. has put in place preventative measu to reduce the spread of COVID-19; however, Orthopedic Physical Therapy, Inc. CANNO guarantee that you will not become infected with COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 while visiting Orthopedic Physical Therapy, Inc. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but no limited to, personal injury, disability, and death), illness, damage, loss, claim, liability; c expense, of any kind, that I may experience or incur in connection with my attendance Orthopedic Physical Therapy, Inc. I also, agree to communicate any possible COVID-19 interactions or health concerns with Orthopedic Physical Therapy, Inc, as necessary.

_____ _____

Signature **Date**