VILLAGE PHYSICAL THERAPY
PATIENT-SPECIFIC FUNCTION AND PAIN SCALE

PATIENT NAME:_____ DATE: _____DOB:_____

Please **list 3-5 important activities** that you are unable to do or are having difficulty doing as a result of your pain, injury or surgery. Then **rate the level of difficulty** you are having with the 3-5 activities you listed using the 0-10 scale:

0 is unable to perform the activity; 10 is no difficulty with the activity.

ACTIVITY	PATIENT SPECIFIC ACTIVITY SCORING SCALE
Example only: Walking up stairs	
1.	**Unable** **No difficulty** 0 1 2 3 4 5 6 7 8 9 10
2.	**Unable** **No difficulty** 0 1 2 3 4 5 6 7 8 9 10
3.	**Unable** **No difficulty** 0 1 2 3 4 5 6 7 8 9 10
4.	**Unable** **No difficulty** 0 1 2 3 4 5 6 7 8 9 10
5.	**Unable** **No difficulty** 0 1 2 3 4 5 6 7 8 9 10

Please rate your pain on the following scale ⟹	0-10 NUMERIC PAIN RATING SCALE
Current	**No pain** **Moderate pain** **Worst pain** 0 1 2 3 4 5 6 7 8 9 10
Best	**No pain** **Moderate pain** **Worst pain** 0 1 2 3 4 5 6 7 8 9 10
Worst	**No pain** **Moderate pain** **Worst pain** 0 1 2 3 4 5 6 7 8 9 10

VILLAGE PHYSICAL THERAPY INTAKE PACKET
MEDICAL HISTORY FORM

PATIENT NAME:_____ DOB: _____AGE:_____ DATE: _____

Area(s) for which you are receiving therapy: _____

Date of injury (if any): _____ Approximate date of onset: _____

How did symptoms begin? _____

_____

Check all that apply to current condition:

- ☐ Work-related injury
- ☐ Motor vehicle accident
- ☐ Cause unknown
- ☐ Recurrence of previous injury
- ☐ Injury related to lifting
- ☐ Athletic/recreational injury
- ☐ Injury related to fall
- ☐ Other:_____

Are you currently working? ☐ Yes ☐ No If yes, please list job title:_____

Please list primary leisure activities:_____

_____

Are you pregnant? ☐ Yes ☐ No ☐ N/A If yes, please list due date:_____

Last seen by referring physician (date): _____ Next appointment_____

List any diagnostic testing you have had for this area: ☐ X-ray ☐ MRI ☐ CT scan ☐ EMG

Results: _____

Have you had treatment for this area before? ☐ Yes ☐ No If yes, date last treated:_____

If yes, please explain (surgery, hospitalization, PT, injections, etc): _____

_____

List any allergies (latex, aspirin, drugs, food, etc.): _____

Past surgical history (type and date): _____

_____

_____

VILLAGE PHYSICAL THERAPY INTAKE PACKET
MEDICAL HISTORY FORM

PATIENT NAME: _____ DATE: _____

Are you currently being treated by another physician or therapist (for any medical condition)? ☐ Yes ☐ No

If yes, please list treatment and condition: _____

_____

Check any symptoms you are currently experiencing:

☐ Sudden/unexpected weight loss/gain	☐ Changes in appetite	☐ Fevers/chills/sweats	☐ Lethargy
☐ Depression/anxiety	☐ Shortness of breath	☐ Increased pain at night	☐ Fatigue/weakness
☐Changes in bowel/bladder	☐Nausea/vomiting	☐Numbness/tingling	☐Poor balance/falls

Do you have any of the following?	Yes	No		Yes	No
Diabetes	☐	☐	Blood disorder/bleeding problems	☐	☐
High blood pressure	☐	☐	Allergy to heat	☐	☐
Heart disease	☐	☐	Allergy/poor tolerance to cold	☐	☐
Heart attack	☐	☐	Multiple sclerosis	☐	☐
Heart palpitations/chest pain	☐	☐	Hernia	☐	☐
Pacemaker	☐	☐	Seizures	☐	☐
Headaches	☐	☐	Metal implants	☐	☐
Kidney problems	☐	☐	Dizziness/fainting	☐	☐
Cancer	☐	☐	Recent fracture(s)	☐	☐
Osteoporosis	☐	☐	Skin abnormalities	☐	☐
Osteoarthritis	☐	☐	Nausea/vomiting	☐	☐
Bowel/bladder abnormalities	☐	☐	Ringing in ears	☐	☐
Asthma/breathing difficulties	☐	☐	Rheumatoid arthritis	☐	☐
Liver/gallbladder problems	☐	☐	Stroke/CVA	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Other:_____	☐	☐	Alcoholism/chemical dependency	☐	☐

Any other conditions not listed above:_____

_____

Are your symptoms currently (circle one): ☐Getting better / ☐About the same / ☐Getting worse

VILLAGE PHYSICAL THERAPY INTAKE PACKET
MEDICATION QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

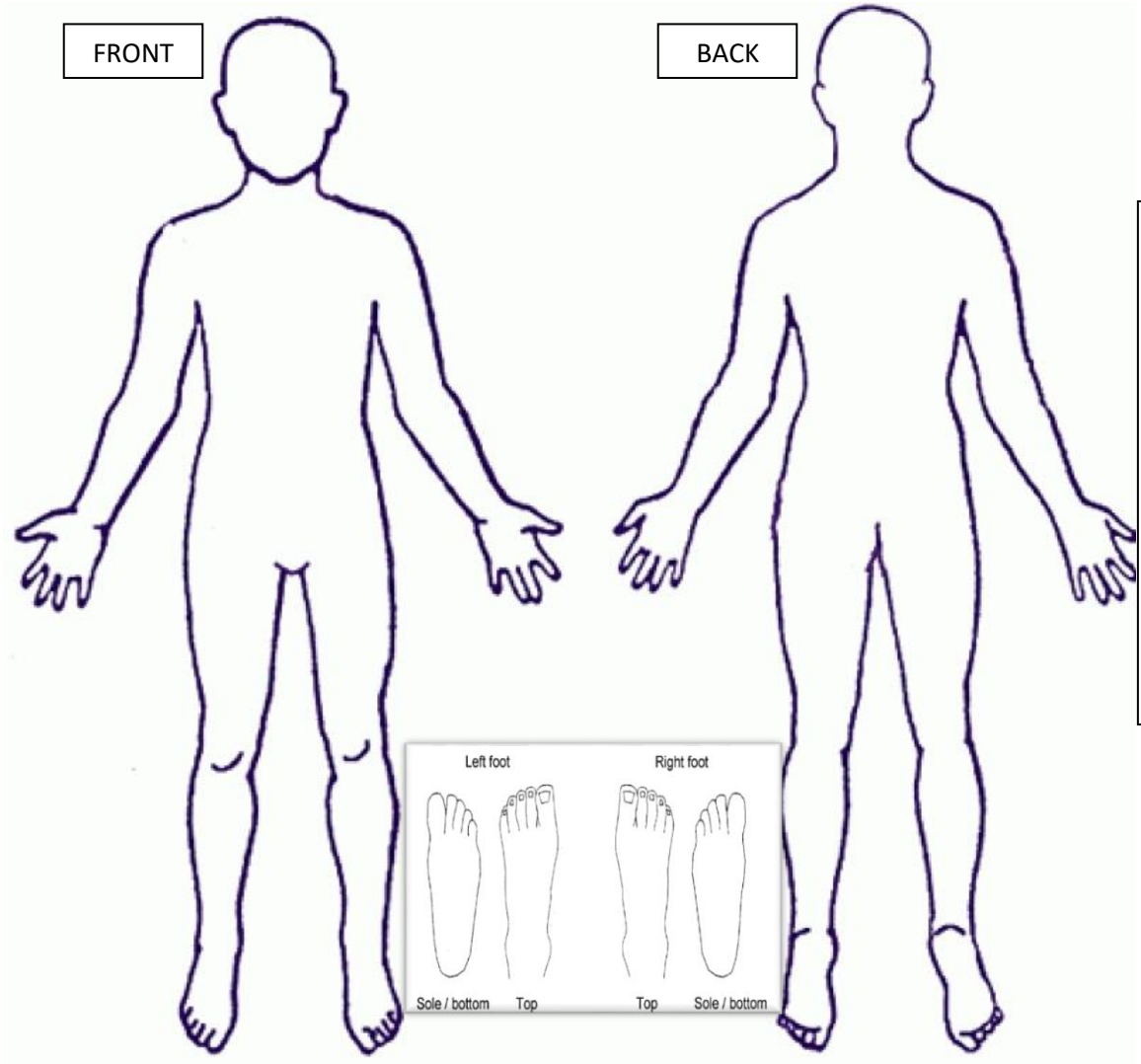
Do you take any prescription medications and/or over-the-counter medications? ☐ Yes ☐ N/A
If you do take any prescription medications and/or over-the-counter medications, please list each medication below:

Medication Name	Type of Medication (over the counter or prescription)	Dosage (milligrams, ounces, etc.)	Frequency (how many times per day or week)	Route of Administration (oral, injection or topical)

SYMPTOM QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

Using the key provided, please **draw the symbol representing your pain** over the area of the body as it relates to your present condition:



Key:

++++ Pins/needles

XXXX Burning

//// Stabbing

0000 Deep ache

What are your personal goals for therapy at this time: _____

_____

To the best of my knowledge, the above information is true and correct.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or if authorized by the patient.)

Physical Therapist signature: _____ Date: _____

CONSENT FORM

PATIENT NAME: _____ DATE: _____

Consent for treatment:

I hereby authorize Nova Orthopaedic and Spine/Village Physical Therapy, through its appropriate therapy personnel, to perform evaluation and treatment procedures deemed necessary by the therapist on me or the above-named patient, if different than myself.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or if authorized by the patient.)

Authorization to Release Information/Assignment of Benefits:

I hereby authorize Nova Orthopaedic and Spine/Village Physical Therapy to release to appropriate agencies any information acquired in the course of my or the above-named patient's evaluation and treatment necessary to process claims and pay Nova Orthopaedic and Spine/Village Physical Therapy directly for professional services rendered.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or if authorized by the patient.)

Acknowledgement of Receipt of Privacy Notice (HIPAA):

I acknowledge that I have received or was offered the Notice of Privacy Practices for Nova Orthopaedic and Spine/Village Physical Therapy.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or if authorized by the patient.)

Cancellation/No-Show Policy:

I understand that 24 hours' notice is required for cancellation of an appointment except in the event of emergency situations. If I fail to cancel my appointment without 24 hours' notice and/or do not show up for my appointment, Nova Orthopaedic and Spine/Village Physical Therapy may **charge $50.00 to be paid by me not by my insurance.** If I missed 3 appointments in a row, in addition to the no-show charge, future appointments will be cancelled.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or if authorized by the patient.)