Buckeye Spine & Rehab Physical Therapy

2036 Schorrway Drive Lancaster, Ohio 43130
Phone: **740-681-1582** ext.**126** Fax: 740-681-1586
Alice Moneypenny PT, Nicole Newlon PTA, Cole Huffman PTA

Patient Name: _____

Evaluation Scheduled: _____at _____ AM / PM

If for any reason you are unable to keep this or any appointment, we ask that you contact our office as soon as possible. (740) 681-1582** ext.**126

FIRST VISIT:

- Your evaluation will be performed by the licensed Physical Therapist and will last one hour.
- Fill out the information on the opposite side of this sheet and arrive 15 minutes before your appointment time.
- For appointments at 7:00 am or 1:00 pm, arrive at those times as our office will not be open until those times.
- Wear comfortable, loose fitting clothing allowing access to area to be treated
- **24 hour notice must be given to cancel or reschedule your evaluation, failure to do so will result in a $25 fee to reschedule your appointment.**

FOLLOW-UP VISITS:

- All follow up appointments may be performed by a licensed Physical Therapist Assistant and last 45 minutes.
- Please inform your therapist of upcoming visits with your referring doctor.
- Patients participating in Pool Therapy, bring a towel and bathing suit or clothing appropriate for the pool (No cut-offs or denim). We provide a changing room and a shower room for your convenience. Please be changed and ready to begin by the time of your appointment.
- Due to limited waiting space, we ask non-patients to wait in the large waiting room at the other end of the building (exceptions will be made for minors and elderly). **Children are not permitted in the physical therapy area.**

We are pleased to have you participate in physical therapy at our facility. We strive to deliver the highest quality care in a timely manner. In order for us to do this we need your assistance.

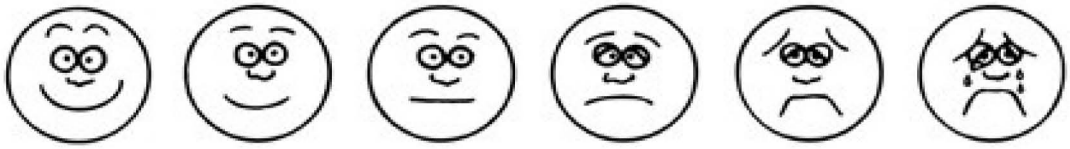
- **If you miss (No Show/Cancel) a combination of two appointments, we reserve the right to discontinue your treatment and we will inform your doctor of your status.**
- Please be consistently on time for your appointments. Tardiness of ten minutes or more may result in necessary modifications or cancellation of your treatment that day.
- If you need to cancel an appointment please notify us at your earliest opportunity so other patients may be seen in your time slot. If no one answers leave a message on our voice mail. ***(740) 681-1582** ext.**126***

Our goal is make your treatment as beneficial and rewarding as possible. We will do our best to stay on schedule and minimize your waiting period. Please respect our time as well as the time of other patients by being punctual for your appointment. We welcome your comments or concerns.

I have read and understand the above and agree to abide by it.

Patient/Responsible party: _____Date:_____

Pain Scale



0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Discomforting		Distressing		Intense		Excruciating
		annoying nagging		troublesome grueling numbing		miserable agonizing gnawing		dreadful horrible cramping		unbearable torturing tearing

(OVER)

Buckeye Spine & Rehab Physical Therapy Medical Summary

Patient Name:_____ Referring Physician:_____

Name you prefer to be addressed by:_____ Family Physician:_____

Best Phone Number to Reach You: _____ email:_____

Emergency Contact:_____ Phone Number:_____

Have you had previous physical therapy this year? □ no □ yes: where and how many visits:_____

Have you been treated at Buckeye Spine & Rehab Physical Therapy before? □ no □ yes: when:_____

Date of Injury/Onset of Symptoms:_____ How it happened:_____

Where is your pain associated with this onset of symptoms? Circle: L for Left R for Right

□ Headaches □ Shoulder L R □ Elbow L R □ Wrist L R □ Hand L R

□ Hip L R □ Knee L R □ Ankle L R □ Foot L R □ other:

□ Back: Does it go down your leg? □ No □ Yes: L R How far? □ thigh □ knee □ ankle □ foot

□ Neck: Does it go down your arm? □ No □ Yes: L R How far? □ shoulder □ elbow □ wrist □ hand

Are your symptoms: □ constant? □ intermittent? □ at night? worst in □ AM □ PM?

What words best describe your pain, check all that apply:

□ sharp □ shooting □ throbbing □ cramping □ stabbing □ aching □ burning

□ squeezing □ numb □ tingle □ other: _____

What makes your symptoms better?

□ laying down □ sitting □ standing □ walking □ other: _____

What makes your symptoms worse?

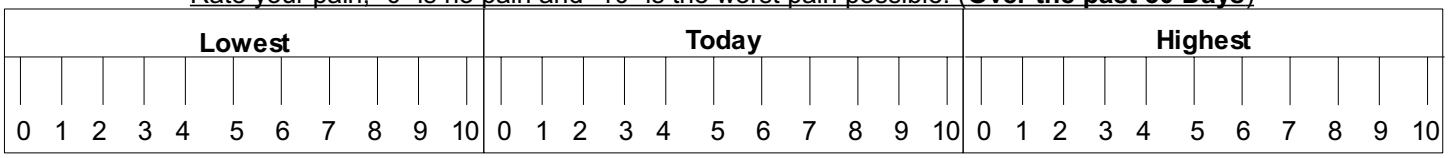
□ laying down □ sitting □ standing □ walking □ working □ recreation □ daily activities

□ other:_____

Do you have weakness? □ yes □ no If yes, where:

Do you have numbness? □ yes □ no If yes, where:

Rate your pain, "0" is no pain and "10" is the worst pain possible: (**Over the past 30 Days**)



Please rate the level of difficulty you have with each task below:

	No difficulty	Moderate (I need help)	Severe (I cannot perform)
Dress, groom and care for myself	□	□	□
Do daily home activities/chores	□	□	□
Do work activities	□	□	□

Employer:_____ Occupation:_____

Are you currently working?: □ working □ working with restrictions □ retired □ student

□ unemployed □ temporary disabled □ disabled

MEDICATIONS (we will make a copy if you have a list): □ None

_____

INJURIES & SURGERIES □ None:_____

Please check all that apply: □ Hip/Knee Replaced □ C-Section □ Back/Neck Surgery

□ Heart Problems □ Smoking □ Seizures □ Depression □ Fibromyalgia

□ High Blood Pressure □ Cancer □ Head Injury □ Anxiety □ HIV/AIDS

□ Diabetes □ Asthma □ Vision Problems □ Arthritis □ Latex Allergy

□ Pacemaker □ Other:_____

Please sign below to state that the above information is true to the best of your knowledge

Signature:_____Date:_____