



Oliver Physical Therapy, PLLC at
Achievement Therapy & Wellness
2504 Genesee St, Suite IB
Utica, NY 13502
(315) 765-0063
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**Welcome to
Physical Therapy Services
for
Lower Body Orthopedic or Sports Conditions
(Hip, Thigh, Knee, Shin, Calf, Ankle, Foot)**

Achievement Therapy & Wellness is a multi-specialty center including physical therapy, occupational therapy and a variety of health and wellness programs. Our mission is to positively impact the health and wellness of community members locally, nationally and globally. We believe in paying it forward. A portion of all our proceeds supports people with disability locally, nationally, and globally, through our rehabilitation clinic in Haiti.

Our physical therapy services, provided through Oliver Physical Therapy, PLLC, specialize in the evaluation and treatment of a full range of musculoskeletal and neuromuscular conditions including post-surgical, orthopedic and sports injuries for our clients.

What to Expect at your First Appointment?

Your first visit will include a variety of tests and measures to determine the most appropriate treatment plan for your condition. Your first appointment will last approximately 60 minutes. Follow-up appointments are usually about 40 minutes.

Important!

Bring this completed packet, your Photo ID, Insurance Card and List of Medications to your appointment.

Please arrive at least 15 minutes early to ensure all paperwork and authorizations are complete prior to your visit.



Patient Information

Name: _____ Middle: _____ Last: _____ Male Female
Address: _____ Apt/Unit: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Email: _____
Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Age: _____
Emergency Contact: _____ Phone #: _____
Relationship: _____

Do you live in a Skilled Nursing or Assisted Living Facility, or Rehab Center? Yes No
Name: _____ Phone #: _____

Are you receiving Home Care Services? Yes No
EMPLOYMENT STATUS: Full Time Part Time Retired Not Employed
Employer: _____
Address: _____

Medical Doctor Information

Referring Physician: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip: _____
Family Physician: _____ Phone #: _____

Please state briefly the nature of your problem: _____

Consent for Treatment The patient/legal guardian authorizes ATW / Oliver Physical Therapy staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Initial here _____

Consent to Release Medical Information I authorize ATW / Oliver Physical Therapy Services to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and _____

Initial here _____

Cancellation/No Show Policy I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and affects other patients as well. Appointments missed without sufficient notice (less than 24 hours) will be charged a \$25 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as patient.

Initial here _____

I hereby certify that I understand these rights I acknowledge that I have been informed of ATW/ Oliver Physical Therapy, PLLC's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information.

Initial here _____

I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

Initial here _____

Signature (Patient/Legal Guardian): _____ **Date:** _____



PATIENT NAME: _____

DATE: _____

Do you have, or have you had, any of the following?

Neurologic

- Migraine
- Stroke/TIA
- If so, when? _____
- Parkinson's Disease
- Seizures/ Epilepsy
- Concussion/Head Injury
- If so, when? _____
- Multiple Sclerosis
- Alzheimer's / Dementia
- Other Neurologic _____

Cardiovascular

- Heart Attack
- If so, when? _____
- Pacemaker
- Peripheral Arterial Disease
- High Blood Pressure
- Low Blood Pressure
- Other Cardiovascular _____

Respiratory

- Breathing Difficulties
- Emphysema/COPD
- Asthma
- Other Respiratory _____

Other Health Issues

Orthopedic

- Artificial Joints
- If yes, which? _____
- Arthritis
- Back Problems
- Back Surgery
- If so, when? _____
- Neck Problems
- Osteoporosis/Osteopenia
- Other Orthopedic _____

Vision

- Cataracts
- If removed, when? _____
- Glaucoma
- Macular Degeneration
- Other Vision _____

Other

- Cancer
- Type: _____
- Diabetes
- Neuropathy
- Depression
- Anxiety
- Thyroid
- Gastrointestinal Problems
- Rheumatoid Arthritis
- Tobacco Use _____
- If yes, how much? _____
- Alcohol Use _____
- If yes, how much? _____



LEFS Outcome Measure

- PLEASE RATE YOUR PAIN LEVEL AT REST: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN**
- PLEASE RATE YOUR PAIN LEVEL WITH ACTIVITY: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN**
- Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **PLEASE CIRCLE THE ANSWERS BELOW THAT BEST APPLY.**

		Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework or school activities	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3	Getting into or out of the bath	0	1	2	3	4
4	Walking between rooms	0	1	2	3	4
5	Putting on your shoes or socks	0	1	2	3	4
6	Squatting	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8	Performing light activities around your home	0	1	2	3	4
9	Performing heavy activities around your home	0	1	2	3	4
10	Getting into or out of a car	0	1	2	3	4
11	Walking 2 blocks	0	1	2	3	4
12	Walking a mile	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14	Standing for 1 hour	0	1	2	3	4
15	Sitting for 1 hour	0	1	2	3	4
16	Running on even ground	0	1	2	3	4
17	Running on uneven ground	0	1	2	3	4
18	Making sharp turns while running fast	0	1	2	3	4
19	Hopping	0	1	2	3	4
20	Rolling over in bed	0	1	2	3	4

For Office Use Only _____ / 80 Calculation: 40/80 x 100% = 50%

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.



(ATHLETES ONLY TO COMPLETE)

FAAM - Sports Subscale

Outcome Measure

1. Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **PLEASE CIRCLE THE ANSWERS BELOW THAT BEST APPLY.**

	Unable to Do	Extreme Difficulty	Moderate Difficulty	Slight Difficulty	No Difficulty
1	0	1	2	3	4
2	0	1	2	3	4
3	0	1	2	3	4
4	0	1	2	3	4
5	0	1	2	3	4
6	0	1	2	3	4
7	0	1	2	3	4
8	How would you rate your current level of function during your sports related activities from 0 to 100, with 100 being your level of function prior to your foot or ankle problem and 0 being the inability to perform any sports activities? _____%				

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N/A responses are not included in the calculation. The score on each of the items are added together to get the item score total. The number of items with a response is multiplied by 4 to get the highest potential score. If the subject answers all 8 items the highest potential score is 32, if one item is not answered the highest potential score is 28, if two are not answered the highest potential score is 24, etc. The item score total is divided by the highest potential score. This value is multiplied by 100 to get a percentage. A higher score represents a higher level of physical function. For the most valid results it is suggested for the FAAM Sports subscale be generated only when subjects completed 90% or more of the items (7 of 8)

Example:

- 6 items answered > highest potential score = 24 (6 items x 4 points)
- Total item score completed by patient = 10
- Calculation: $10/24 \times 100\% = 41.6\%$

MCID = 9% points