



Achievement Therapy & Wellness  
Oliver Physical Therapy, PLLC  
2504 Genesee St, Suite IB  
Utica, NY 13502  
(315) 765-0063  
atwcny.com

**Welcome to  
Physical Therapy Services  
for  
Upper Body Orthopedic or Sports Conditions  
(Shoulder, Elbow, Wrist, Hand)**

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? \_\_\_\_\_





# QuickDASH Outcome Measure

1. **PLEASE RATE YOUR PAIN LEVEL AT REST:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN
2. **PLEASE RATE YOUR PAIN LEVEL WITH ACTIVITY:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN
3. **Description:** Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1	1	2	3	4	5
2	1	2	3	4	5
3	1	2	3	4	5
4	1	2	3	4	5
5	1	2	3	4	5
6	1	2	3	4	5
	<b>Not At All</b>	<b>Slightly</b>	<b>Moderately</b>	<b>Quite A Bit</b>	<b>Extremel y</b>
7	1	2	3	4	5
	<b>Not Limited At All</b>	<b>Slightly Limited</b>	<b>Moderately Limited</b>	<b>Very Limited</b>	<b>Unable</b>
8	1	2	3	4	5
	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extreme</b>
9	1	2	3	4	5
10	1	2	3	4	5
	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe Difficulty</b>	<b>So Much Difficulty That I Can't Sleep</b>
11	1	2	3	4	5