



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

**Welcome to
Physical Therapy Services
for
Lower Body Orthopedic or Sports Conditions
(Hip, Thigh, Knee, Shin, Calf, Ankle, Foot)**

Achievement Therapy & Wellness is an outpatient center including physical 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.

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: _____
Date of Birth: ____/____/____ Age: _____
Emergency Contact: _____ Phone #: _____
Relationship: _____

Are you receiving Home Care Services? Yes No
Are you receiving Chiropractor services? Yes No
Are you receiving Physical Therapy services at another facility? Yes No

EMPLOYMENT STATUS: Full Time Part Time Retired Not Employed
Employer: _____

Medical Doctor Information (Complete only if not on your physical therapy prescription)

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

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:** _____



Medical History

PATIENT NAME: _____ DATE: _____

Please list all your past medical conditions and surgeries

Please list all your current medications and supplements

Please list recent Tests or Medical Imaging that you have had regarding this condition in the last year



Patient Symptom Survey

PATIENT NAME: _____ DATE: _____

What brings you here today? _____

When did your symptoms begin? _____

What were you doing when it came on? _____

Have you had any recent medication changes, falls or illnesses prior to this condition? No Yes, _____

Have you had any recent surgeries that may have contributed to this condition? No Yes, _____

What is your main problem or primary concern? _____

What was your level of function previously?

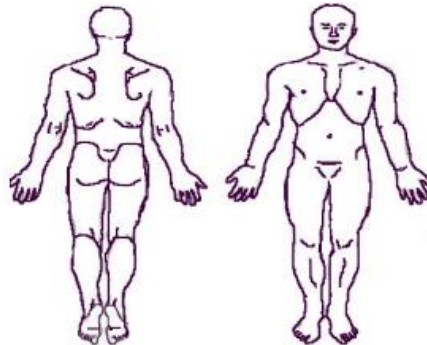
Independent with all activities or I had difficulty with some things such as _____

Circle all the areas you have difficulty with?

Self-Care
Mobility: Walking & Moving Around
Sleep Driving Work
Other: _____

Changing Body Positions & Maintaining Body Position
Carrying, Moving & Handling Objects
Social Activities Hobbies, Leisure, Sport Activities

Pain: Draw your pain on the body chart



Rate your pain on a scale of 0 -10 (0 being no pain - 5 being moderate pain - 10 being pain extreme pain)

At worst: 0 1 2 3 4 5 6 7 8 9 10
Current: 0 1 2 3 4 5 6 7 8 9 10
At best: 0 1 2 3 4 5 6 7 8 9 10

Pain Description: Circle all that apply:

Burning Sharp Dull/Achy Throbbing Shooting Numbness/Tingling Constant Intermittent
Worse in AM Worse in PM Worse at Night Other: _____

Circle all the things that aggravate this condition:

Sitting Standing Walking Stairs- up Stairs down Bending Voiding Lying Down Cough/Sneeze
Turning Rising AM As the Day progresses PM When still When on the move
Other: _____

Are your current Symptoms improving, worse or the same overall? _____

What are your goals of therapy? _____



LEFS 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: 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%



(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 Jumping	0	1	2	3	4
2 Landing	0	1	2	3	4
3 Starting and stopping quickly	0	1	2	3	4
4 Cutting /lateral movements	0	1	2	3	4
5 Low impact activities	0	1	2	3	4
6 Ability to perform activity with your normal technique	0	1	2	3	4
7 Ability to participate in your desired sport as long as you would like	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