Achievement Therapy & Wellness
Oliver Physical Therapy, PLLC
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atwcny.com

Welcome to Physical Therapy Services for Back Conditions

Achievement Therapy & Wellness is a multi-specialty 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? ____
____

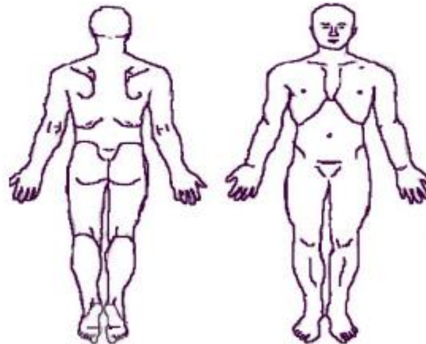
What was your level of function previously?

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

Circle all the areas you have difficulty with?

Self-Care
Changing Body Positions & Maintaining Body Position
Mobility: Walking & Moving Around
Carrying, Moving & Handling Objects
Sleep Driving Work
Social Activities Hobbies, Leisure, Sport Activities
Other: ____

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? ____
____

FOR BACK PATIENTS ONLY

Modified Oswestry Low Back Pain 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.**

1. Pain Intensity

(0) I can tolerate the pain I have without having to use pain medication
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from pain.
(5) Pain medication has no effect on my pain

2. Personal Care (washing, dressing, etc)

(0) I can look after myself normally without causing increased pain.
(1) I can look after myself normally, but it increases my pain.
(2) It is painful to take care of myself, and I am slow and careful.
(3) I need help but I am able to manage most of my personal care.
(4) I need help every day in most aspects of care.
(5) I do not get dressed, wash with difficulty and stay in bed

3. Lifting

(0) I can lift heavy weights without extra pain.
(1) I can lift heavy weights but it causes increased pain.
(2) Pain prevents me from lifting heavy weighs off the floor, but I can manage if they are conveniently positioned (eg, on a table).
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. Walking

(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from walking more than 1 mile.
(2) Pain prevents me from walking more than 1/2 mile.
(3) Pain prevents me from walking more than 1/4 mile.
(4) I can only walk with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting

(0) I can sit in any chair as long as I like
(1) I can only sit in my favorite chair as long as I like
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than 1/2 hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) Pain prevents me from sitting at all.

6. Standing

(0) I can stand as along as I want without increased pain.
(1) I can stand as long as I want but, it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than 1/2 hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

7. Sleeping

(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hours.
(5) Pain prevents me from sleeping at all.

8. Social Life

(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

9. Traveling

(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys under ½ hour.
(5) My pain prevents all travel except for visit to the physician/therapist or hospital.

10. Employment / Homemaking

(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg. lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.

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

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