



Achievement Therapy & Wellness
Oliver Physical Therapy, PLLC
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Welcome to Physical Therapy Services for Neck 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

Mobility: Walking & Moving Around

Sleep

Driving

Work

Other: _____

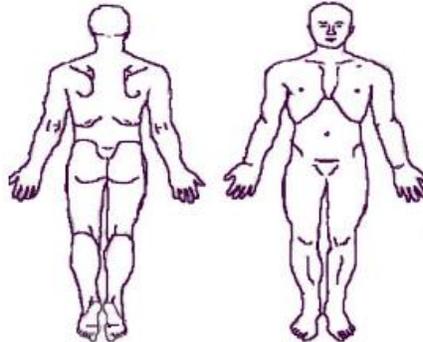
Changing Body Positions & Maintaining Body Position

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? _____



FOR NECK PATIENTS ONLY

Neck Disability Index 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.**

<p>1. Pain Intensity</p> <ul style="list-style-type: none"> (0) I have no pain at the moment. (1) The pain is very mild at the moment. (2) The pain is moderate at the moment. (3) The pain is fairly severe at the moment. (4) The pain is very severe at the moment. (5) The pain is the worst imaginable at the moment. 	<p>6. Reading</p> <ul style="list-style-type: none"> (0) I can read as much as I want with no pain in my neck. (1) I can read as much as I want with slight neck pain. (2) I can read as much as I want with moderate neck pain. (3) I can't read as much as I want because of moderate neck pain. (4) I can hardly read at all because of severe neck pain. (5) I cannot read at all because of neck pain.
<p>2. Personal Care (washing, dressing, etc)</p> <ul style="list-style-type: none"> (0) I can look after myself normally without extra pain. (1) I can look after myself normally, but it causes extra pain. (2) It is painful to look after myself and I am slow and careful. (3) I need some help but manage most of my personal care. (4) I need help every day in most aspects of self care. (5) I cannot get dressed, wash with difficulty and stay in bed 	<p>7. Work</p> <ul style="list-style-type: none"> (0) I can do as much as I want to. (1) I can only do my usual work but no more. (2) I can do most of my usual work but no more. (3) I cannot do my usual work. (4) I can hardly do any usual work at all. (5) I can't do any work at all.
<p>3. Lifting</p> <ul style="list-style-type: none"> (0) I can lift heavy weights without extra pain (1) I can lift heavy weights but it gives me extra pain (2) Pain prevents me from lift heavy weighs off the floor but I can manage if they are on a table. (3) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed. (4) I can lift only very light weights (5) I cannot lift or carry anything at all. 	<p>8. Sleeping</p> <ul style="list-style-type: none"> (0) Pain does not prevent me from sleeping well. (1) My sleep is slightly disturbed (<1 hr sleep loss) (2) My sleep is mildly disturbed (1-2 hr sleep loss) (3) My sleep is moderately disturbed (2-3 hr sleep loss) (4) My sleep is greatly disturbed (3-4 hr sleep loss) (5) My sleep is completely disturbed (5-7 hr sleep loss)
<p>4. Headache</p> <ul style="list-style-type: none"> (0) I have no headaches at all. (1) I have slight headaches which come infrequently. (2) I have moderate headaches which come infrequently. (3) I have moderate headaches which come frequently. (4) I have severe headaches which come infrequently. (5) I have headaches almost all the time. 	<p>9. Concentration</p> <ul style="list-style-type: none"> (0) I can concentrate fully when I want with no difficulty. (1) I can concentrate fully when I want with slight difficulty. (2) I have a fair degree of difficulty concentrating when I want. (3) I have a lot of difficulty concentrating when I want. (4) I have great difficulty concentrating when I want. (5) I cannot concentrate at all.
<p>5. Recreation</p> <ul style="list-style-type: none"> (0) I am able to engage in all my recreational activities without pain. (1) I am able to engage in my recreational activities with some pain. (2) I am able to engage in most but not all of my usual recreational activities because of my neck pain. (3) I am able to engage in a few of my usual recreational activities with some neck pain. (4) I can hardly do any recreational activities because of my neck pain. (5) I can't do any recreational activities at all. 	<p>10. Driving</p> <ul style="list-style-type: none"> (0) I can drive my car without neck pain. (1) I can drive my car as long as I want with slight neck pain. (2) I can drive my car as long as I want with moderate neck pain. (3) I can't drive my car as long as I want with moderate neck pain. (4) I can hardly drive my car at all because of severe neck pain. (5) I can't drive my car at all.