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

Welcome to Physical Therapy Services for Neurological Conditions

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.

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, _____
_____

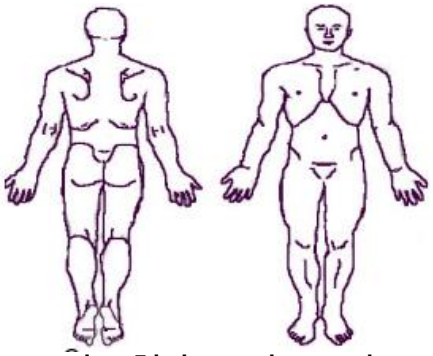
Have you had any recent surgeries that may have contributed to this condition? No Yes, _____
_____

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? _____
_____

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%

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