CENTRAL OHIO PRIMARY CARE Physical Therapy

Name:_____ **Date:**_____

Age:____ **Sex**: Male___ Female___ **Dominant Hand**: Right___ Left___

Diagnosis:_____

1. Pain is difficult to describe. Circle the words that best describe your symptoms:

Burning Throbbing Aching Stabbing Tingling Twisting Squeezing
Cramping Cutting Shooting Numbing Vague Stinging Indescribable
Pulling Smarting Pressure Coldness Dull Other: _____

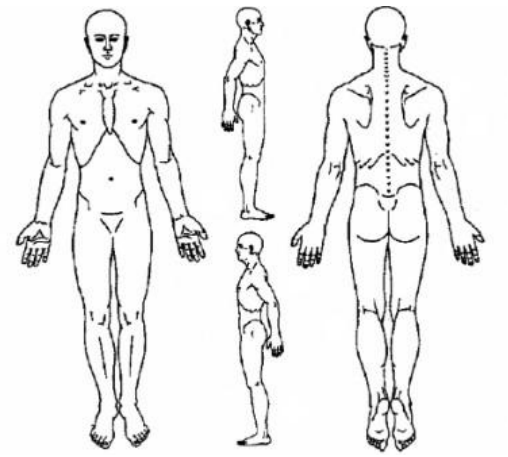
Level of symptoms: place a mark through the line to indicate the level of your pain, if zero is no pain and the end of the line is the most severe pain you can imagine having.

2. Mark your *average* level of pain *in the last month*
1_____5_____10
No Pain Most Severe Pain

3. Mark your *worst* level of pain *in the last week*
1_____5_____10

4. Mark on this scale how your pain has affected your quality of life:
1_____5_____10
Very Little A large amount

5. Where is your pain? (Draw on diagram)



Name _____

6. How did the pain that you are now experiencing occur?
Sudden onset Slow progressive onset "Flare up" of a prior injury

7. Does movement have any effect on your pain?
Makes it better Makes it worse No change

8. Does weather have any effect on your pain?
Makes it better Makes it worse No change

9. Do you have trouble with sleep because of your pain?
Trouble falling asleep awakened from sleep No trouble sleeping

10. Are you involved in any legal action regarding your physical complaint?
No Yes

11. Are you presently a victim of abuse?
No Yes No comment

12. Are you able to do your normal work and/or household chores?
Limited a lot Limited a little Not limited at all

13. How would you rate your overall health?
Excellent Good Fair Poor

Describe the problem for which you seek physical therapy _____
_____
_____

Describe how are you taking care of the problem now _____
_____

Describe what makes the problem better and what makes it worse _____
_____
_____
_____

Please list your goals for physical therapy. What would you like to be able to do when you are finished? Please be as specific as possible.

_____
_____
_____
_____
_____

If there is any medical or medication history that has changed since the last time you saw your doctor? _____
_____

LOWER EXTREMITY FUNCTIONAL SCALE

Patient Name:_____

Date:_____

We are interested in knowing whether you are having difficulty at all with the activities listed below because of your lower limb/hip problem for which you are currently seeking attention.
Please provide an answer for each activity.

Today do you, or would you have difficulty at all with:

	Extreme Difficulty or Unable to Perform Activity	Quite a bit of Difficulty	Moderate Difficulty	A little bit of Difficulty	No Difficulty
A. Any of your usual work, housework or school acitivites.	0	1	2	3	4
B. Your usual hobbies, recreation or sporting activities.	0	1	2	3	4
C. Getting into or out of the bath.	0	1	2	3	4
D. Walking between rooms.	0	1	2	3	4
E. Putting on your shoes and socks	0	1	2	3	4
F. Squatting	0	1	2	3	4
G. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
H. Performing light activities around your home.	0	1	2	3	4
I. Performing heavy activities around your home.	0	1	2	3	4
J. Getting into or out of car.	0	1	2	3	4
K. Walking 2 blocks.	0	1	2	3	4
L. Walking a mile.	0	1	2	3	4
M. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
N. Standing for one hour.	0	1	2	3	4
O. Sitting for one hour.	0	1	2	3	4
P. Running on even ground.	0	1	2	3	4
Q. Running on uneven ground.	0	1	2	3	4
R. Making sharp turns while running fast.	0	1	2	3	4
S. Hopping.	0	1	2	3	4
T. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS					

SCORE:_____/80 _____%

Binkley JM, Stratfor POW, Lott SA, Riddle DL. The lower extremity function scale (LEFS): Scale development, measurement properties, and clinical application. Physcial Therapy 1999; 79:371-383

Westerville Physical Therapy
Northwest Physical Therapy
Sports, Spine and Joint Physical Therapy

614-392-2812

CENTRAL OHIO℠
PRIMARY CARE

Eastside Physical Therapy
614-865-3142

Valued COPC Physical Therapy Patient:

At Central Ohio Primary Care, it is our goal to give you the best care possible. In order to best serve all of our patients, we request the following:

- If you cannot keep your scheduled appointment, please call us at the number above to cancel the appointment at least 24 hours prior to the visit.
- If you miss an appointment, and fail to call to re-schedule or cancel, you may be assessed a No Show/Late Cancelation fee of $50.00 for an initial evaluation or $25.00 for an established follow-up visit.
- If you have 3 cancellations within a consecutive 3 week period, the Physical Therapist will be notified and will determine if your therapy should resume, or be discontinued.
- If you will be more than 10 minutes late, we may ask you to re-schedule your appointment. This will assure that we are giving you the full time you deserve to address all of your needs during treatment.

Thank you for helping us to provide our patients with the most convenient scheduling possible!

I have read this physical therapy policy and agree to the above.

Today's Date: _____

Printed Name: _____

Signature: _____