

**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

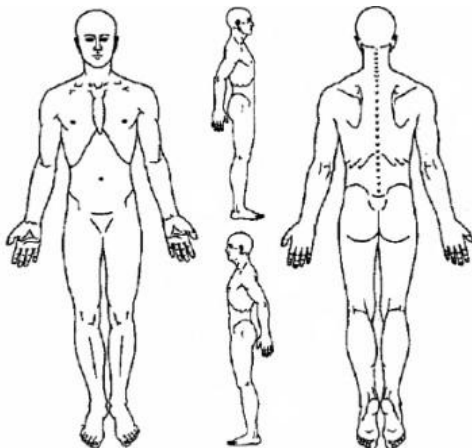
3. Mark your worst level of pain in the last week

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? \_\_\_\_\_  
\_\_\_\_\_

# The Modified Falls Efficacy Scale

Name \_\_\_\_\_

Date \_\_\_\_\_

On a scale of 0 to 10, please rate how confident you are that you can do each of these activities without falling, with 0 meaning "not confident/not sure at all", 5 being "fairly confident/fairly sure", and 10 being "completely confident/completely sure".

**Note:**

- \* If you have stopped doing the activity at least partly because of being afraid of falling, score a 0
- \* If you have stopped an activity purely because of a physical problem, leave that item blank (these items are not included in the calculation of the average MFES score).
- \* If you do not currently do the activity for other reasons, please rate that item based on how you perceive you would rate it if you had to do the activity today.

		Not Confident			Fairly Confident					Completely Confident		
	Activity	0	1	2	3	4	5	6	7	8	9	10
1.	Get dressed and undressed											
2.	Prepare a simple meal											
3.	Take a bath or a shower											
4.	Get in/out of a chair											
5.	Get in/out of bed											
6.	Answer the door or telephone											
7.	Walk around the inside of your house											
8.	Reach into cabinets or closet											
9.	Light housekeeping											
10.	Simple shopping											
11.	Using public transport											
12.	Crossing roads											
13.	Light gardening or hanging out the washing *											
14.	Using front or rear steps at home											

\* Rate most commonly performed of these activities

Score/Item Rated= \_\_\_\_/\_\_\_\_

Average= \_\_\_\_



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 Cancellation 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: \_\_\_\_\_



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Acct. # \_\_\_\_\_

### Agreement of Financial Responsibility

Thank you for choosing **Central Ohio Primary Care Physicians, Inc. (COPC)** as your health care provider. COPC is committed to providing quality care and service to all of our patients. The following is a statement of COPC's financial policy, which we require that you read and agree to prior to receiving any treatment from COPC.

Payment of your bill is considered part of your treatment. Fees are due and payable when services are rendered. COPC accepts cash, check, credit cards, and pre-approved insurance for which COPC is a contracted provider.

It is your responsibility to know your own insurance benefits, including:

- whether COPC is a contracted provider with your insurance company;
- your covered benefits and any exclusions in your insurance policy; and
- any pre-authorization requirements of your insurance company.

COPC will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information to COPC, including any updates or changes in your insurance coverage. Should you fail to provide this information, you will be financially responsible for the costs of the services rendered by COPC.

If COPC has a contract with your insurance company, COPC will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

If COPC does not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. COPC will provide you with a statement that you can submit to your insurance company for reimbursement.

Proof of insurance and photo ID are required for all patients. COPC will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Some insurance coverage has Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policy stated above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I acknowledge that if my insurance company denies coverage and/or payment for services provided, I will be financially responsible and will pay all such charges due and owing in full.

\_\_\_\_\_  
Signature of Patient /Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient/Responsible Party (please print)

\_\_\_\_\_  
Relationship to Patient