Patient Name:

____

Appointment Date:______________

Appointment Time:______________

Alabama Orthopaedic Clinic, PC

Therapy Services
3610 Springhill Memorial Drive, N
Mobile, AL 36608
251.410.3690
6:00am – 5:30pm

ALABAMA ORTHOPAEDIC CLINIC, P.C.

Welcome to AOC Therapy Services!

Thank you for choosing us to be a part of your patient care. We would like to take a minute to explain what you should expect from the therapy department in hopes of answering any questions you may have. If at any time you would like to speak with the therapy department directly, please contact us at 251.410.3690.

Office Hours and Appointments

We schedule appointments Monday through Friday, 6:00am until 4:30 pm. We schedule on a first come, first serve basis; therefore, we highly recommend that you schedule the entire duration of your orders, or until your next doctor's appointment. This ensures that you reserve the dates and times that work best for your schedule and it allows us time to update your physician of your progress.**

If you need to cancel or reschedule your appointment, please notify our office as soon as possible so that another patient may use that time slot. ***Patients who are more than fifteen minutes late to their scheduled appointment time are subject to cancellation without notice.****

Therapy Entry Process

A physical/occupational therapy referral from your physician is required before treatment begins. Your insurance will require a referral before treatment as a provision of reimbursement. ***Please notify us immediately if you have had any therapy or home health in the past 12 months as this could affect your insurance coverage.****

Payment Policy

An insurance policy is a contract between you and your insurance company. As a courtesy, Alabama Orthopaedic Clinic will bill insurance companies on your behalf. If an insurance company does not pay all or part of the claim, the patient is responsible for all balances. We are happy to assist you in determining what is covered by your particular policy.

Our financial counselor will contact you before your initial appointment regarding your benefits. If you have questions, our financial counselor can be reached at 251.410.3609. Coverage is different with all policies; therefore, it is ultimately the patient's responsibility to be familiar with their policy and what it covers.

Attire

We recommend that you wear loose, comfortable clothing. Shorts are a good choice for those being treated for hip or leg injuries.

**** It is imperative that you notify us of any changes to your doctor's appointment so we can update him/her of your progress.**

Date:___
Name:___
Date of Birth:___
Phone Number:___

Physical Therapy Medical Questionaire

Gender: Male Female
Height:___
Weight:___
Pregnant: Yes No
Age: ___
Smoker: Yes No
Occupation:___

Describe your regular exercise routine: ___

Past Surgical History:___

Current Medications:___

Have you had an X-Ray, MRI, or other imaging study for this problem?
___Yes - When and where? ___
___ No

Please Circle Each Condition You Have (Or Have Had)

Cancer Diabetes Kidney Disease Liver Disease
High Blood Pressure Heart Disease Angina/Chest Pain Ulcers
Fibromyalgia Osteoporosis Lung Disease Stroke
Any Recent Illness? ___

Do you take blood thinners? Yes No **Are you allergic to Latex?** Yes No
Other Allergies:___

Currently I am experiencing (Circle All that Apply):

Fever/Chills/Sweats Poor Balance/Falls Unexplained Weight Loss Numbness/Tingling
Changes in Appetite Difficulty Swallowing
Shortness of Breath Dizziness Changes in Bowel/Bladder Function Headaches
Nausea/Vomiting Increased Pain at Night

Current Symptoms:

What are your current symptoms?___
What date (approximately) did they begin?___
How? (gradually, suddenly, injury)___
My symptoms are currently: ☐**Getting Better** ☐**About the Same** ☐**Getting Worse**
Have you received any treatment for this problem?___
Have you had this problem before? **Yes No**
If so, how was the problem treated?___
How long did it take for you to feel better?___
How are you able to sleep at night? ☐ **Fine** ☐ **Moderate Difficulty** ☐ **Only With Medication**
What is your personal goal for therapy?___
Do you have any barriers to learning? If so, please list: ___

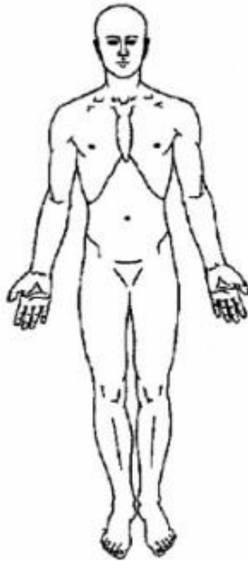
SEE REVERSE

On the scale below, please circle the number which best represents the severity of your pain:

<u>Average</u> for the last 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imagineable

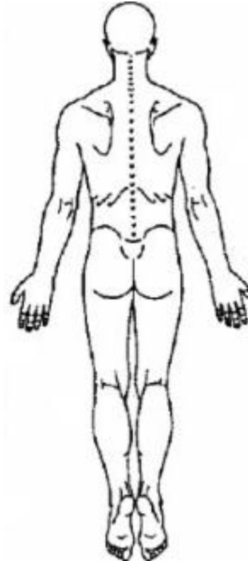
<u>Best</u> for the last 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imagineable

<u>Worst</u> for the last 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imagineable



<u>Pain Diagram</u>

Please mark the area(s) where you feel pain.



Please circle the number which best represents your overall function (on average):

0 1 2 3 4 5 6 7 8 9 **10**
Cannot Do Anything **Able to do Everything**

Please circle the activities that make your pain <u>worse</u>:

Lying Down Standing Walking Stress Sitting Other:______________________

Please circle the activities that make your pain <u>better</u>:

Lying Down Standing Walking Stress Sitting Other:______________________

Please list the best and worst time of day for your symptoms:
Best:____
Worst:____

Aggravating Factors:
Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem.
1.____
2.____
3.____

____

Please sign and date