Patient Name:_____ GW#_____

ALABAMA ORTHOPAEDIC CLINIC, P.C.

THERAPY SERVICES

It is the policy of this clinic that three (3) consecutive “No Show” visits or a total of six (6) cancellations and/or “No Shows” will constitute discontinuation of treatment and patient discharge as well as physician notification of non-compliance.

In order to receive the quality of treatment that AOC Therapy is known to provide, understand the importance of arriving on time or slightly early for each appointment.
I also understand that if **I arrive later than my given appointment time**, that I may/may not receive treatment, depending on the availability of scheduled therapist, and that I may possibly be rescheduled.

I agree to verify/schedule my follow-up appointments at the front desk after each visit. If I am unable to keep an appointment, I will notify AOC Therapy by phone in advance.

I understand the above terms and agree to comply.

_____ _____

Patient Signature **Date**

Patient Name:_____ GW#_____

THERAPY SERVICES

Have you received any Home Health this year?
Yes_____ No_____
If Yes, How many? _____ Which company? _____

Have you attended therapy at any other facilities this year?
Yes_____ No_____
If Yes, How many? _____ Where? _____

Failure to give us the correct information **WILL** result in a balance.

_____ _____
Patient Signature **Date**

GW# _____

ALABAMA ORTHOPAEDIC CLINIC, P.C.

Date:_____

Name:_____

Date of Birth:_____

Therapy Services Medical Questionnaire

Gender: Male Female Age: _____

Height:_____ Weight: _____

Pregnant: Yes No

Smoker: Yes No

Occupation:_____

Describe your regular exercise routine:

_____

_____

Past Surgical History:_____

_____

_____

_____

_____

_____

Are you allergic to Latex? _____Yes _____No

Other allergies: _____

_____

Medical History: (Please list any medical conditions and/or illnesses that you may have or have had)

_____

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

How are you able to sleep at night? ☐ Fine ☐ Moderate Difficulty ☐ Only With Medication

What is your personal goal for therapy?_____

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

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

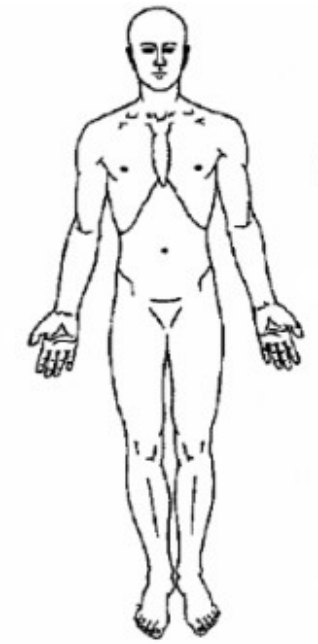
Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Worst for the last 48 hours:

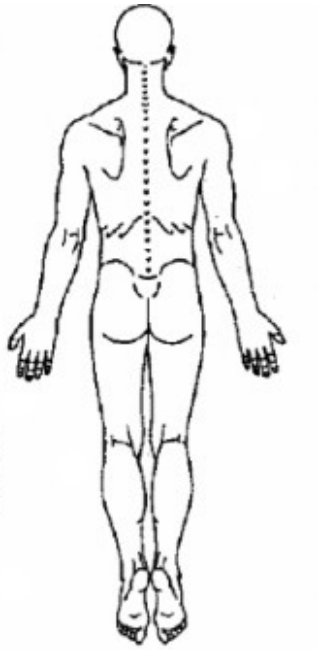
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

GW# _____



Pain Diagram

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 worse:

Lying Down Standing Walking Stress Sitting Other:_____

Please circle the activities that make your pain better:

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._____

Signature: _____ Date: _____