



Therapy Services

Patient Name: _____ GW: _____

Have you received any Home Health in 2022?

Yes _____ No _____

If yes, how many visits? _____ Which Company? _____

Have you attended therapy at any other facility in 2022?

Yes _____ No _____

If yes, how many visits? _____ Where? _____

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

It is the policy of this clinic that three (3) consecutive "no show" visits or a total of six (6) cancelations and "no show" visits 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 Services 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, I may/may not receive treatment, depending on the availability of scheduled therapist, and that my appointment may 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 Services by phone in advance.

I understand the above terms and agree to comply.

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

