



PATIENT QUESTIONNAIRE

NAME _____

PAST MEDICAL HISTORY: (please list any past or present medical conditions that may affect your treatment, i.e. heart condition, asthma,...)

MEDICATIONS: (please list medications that you are currently taking)

Are your symptoms getting better or worse? Better Worse Same

How and when did the injury occur? _____

Please circle your level of pain associated with why you are here (0 = no pain and 10 = unbearable)

0 1 2 3 4 5 6 7 8 9 10

Does the pain interfere with your daily activities? Yes No

Job Status: Full Duty Light Duty (Restrictions) _____ Off Work

Job Title: _____

Requires: Heavy Activity Moderate Activity Light Activity

Have you had any diagnostic testing for your injury/condition?

X-ray MRI Other _____

Goals I want to accomplish from Therapy:

Who or what helped you choose Opti-Health for your therapy?

My doctor Family Friend Radio ad Online ad Newspaper ad Billboard
 Other (please disclose) _____

Patient Signature _____ Date _____

The Opti-Health Group, Inc.
Patient Registration Form

Date: _____

Patient Name: _____
First Middle Last

Address: _____
P.O. Box/Street City State Zip

Telephone: _____ Birthdate: _____ Social Security# _____

Patient Employer or School: _____
Name Address Phone

Sex: M F Marital Status: Single Married Divorced Widowed Diagnosis: _____

Date of Injury/Onset: _____ Parent/Guardian Telephone if different than Patient _____

Address if Different than Patient: _____

Emergency Contact Name: _____ Phone #: _____

Referring Physician: _____
Name Address Phone

PCP: _____ Phone# _____ Fax# _____

Have you been a patient here before: Y or N If so, When: _____

Have you received therapy/chiropractic services elsewhere this year? Y N If so, when: _____

Was your injury work-related? Y N Was your injury related to an auto accident? Y N

Are you currently receiving Home Health care? Y N

PLEASE READ & SIGN BELOW

It is important that you understand your insurance benefits as they relate to physical therapy. Insurance companies can have several options for payment which include visit limits, dollar amount caps, and pre-certification. Your insurance may combine therapy benefits along with other therapy types such as Chiropractic. If you have had therapy services or chiropractic services elsewhere please inform your therapist. It is **your responsibility** to know your benefits and limitations. **Please call your insurance company to get your benefit information.**

I hereby authorize the release of any medical information necessary to process a claim for me and/or my dependent. I also authorize the payment of medical benefits directly to The Opti-Health Group, Inc. for services rendered in my care and/or the care of my dependent(s) realizing **I am personally responsible for the charges incurred, including items determined to be non-covered, and any applicable collection and late charges.** I also authorize The Opti-Health Group, Inc. to render the care ordered by my physician and deemed necessary for this treatment.

Signed _____ Relationship _____ Date _____

Witness _____ Date _____

BILLING INFORMATION
Please complete sections that apply.

PATIENT NAME: _____

NAME OF ATTORNEY: _____ **Phone#** _____

Address: _____

IS THIS A WORKERS COMP CLAIM? Y N **Is your claim allowed?** Y N **Pending?** Y N

Employer _____
Name Address Phone
Workers Comp Claim# _____ **Date of Injury:** _____

MEDICAL INSURANCE INFORMATION:

PRIMARY INSURANCE: _____
Name Address Phone
Group/Policy# _____ **ID#** _____ **Insured DOB:** _____
Insured Name: _____ **Insured Employer:** _____ **Related to Insured:** _____

SECONDARY INSURANCE: _____
Name Address Phone
Group/Policy# _____ **ID#** _____ **Insured DOB:** _____
Insured Name: _____ **Insured Employer:** _____ **Related to Insured:** _____

MOTOR VEHICLE ACCIDENT INFORMATION **Date of Accident:** _____

Were you cited for the Motor Vehicle Accident: Y N **If No, name of person cited:** _____

Name of Your Auto Insurance Carrier: _____
(if bills are to go to your auto insurance)

Address: _____

Phone#: _____ **Agent's Name:** _____

Policy# _____ **Claim#** _____

Name of Responsible Party's Auto Insurance Carrier: _____
(if bills are to go to other person's auto insurance)

Address: _____

Phone#: _____ **Agent's Name:** _____

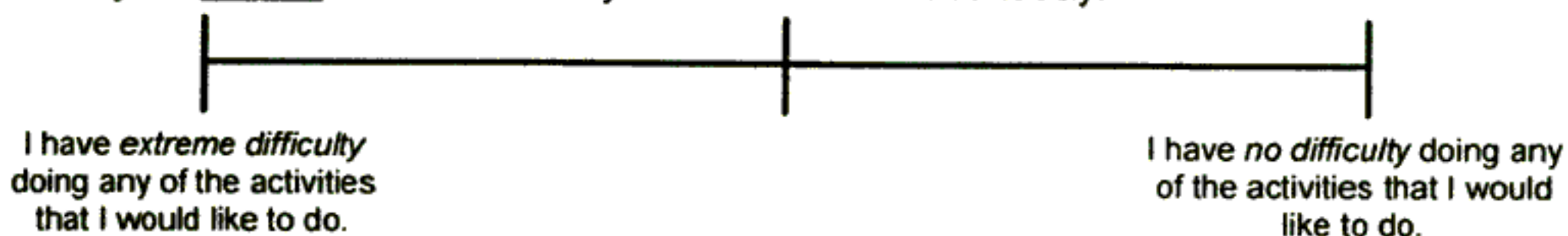
Insured's Name: _____ **Claim #:** _____

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about *all* of the activities you would like to do, please mark an "X" at the point on the line that best describes your *overall* level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13)

1. _____ 2. _____ 3. _____

Confidence–Baseline

Instructions: Please circle the level of confidence you have for doing each activity today.	Fully confident in my ability to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
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13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about *all* the activities you like to do, please mark an "X" at the point on the line that best describes your *overall* level of confidence in performing these activities today:

