ROSEVILLE ORTHOPEDIC
Surgery & Sports Medicine

Physical Therapy
151 N. Sunrise Ave, Suite 1001
Roseville, CA 95661
Tel: 916-782-1217
Fax: 916-218-7466
rosevilleorthopedics.com

Dear Patient,

Welcome to Roseville Orthopedics Physical Therapy. We are pleased that you have chosen us for your rehabilitation needs. Our goal is to provide you with the highest quality care in a clean and professional environment. Before you begin your therapy program, an evaluation will be performed to assess your individual needs. The evaluation will take approximately 60 minutes. It is important that you come to your evaluation at least 15 minutes early to complete necessary paperwork.

When you come for your evaluation, you should bring the following information:

1. Therapy prescription from physician
2. Personal identification
3. Insurance card
4. Co-pay (if applicable)
5. List of medications you are currently taking

Appointments:
Our patients are seen by appointment only. After your evaluation, schedule follow up visits at our reception desk. It is critical that you are on time for your appointments. Being late may make it necessary to shorten your therapy session so it does not disrupt other patients' scheduled appointments.

Appropriate Attire:
Please wear clothes suitable and comfortable to perform exercise. This includes shorts, sweats, athletic sweats and shirt. If you have a knee problem it is best to wear shorts so we can work on your knee, as needed.

Cancellations / Reschedule:
Because we provide services by appointment, it is critical that you allow 24 hour notice if you must cancel an appointment. This is a courtesy to the clinical staff as well as to other patients. Habitual cancellations may lead to discontinuation of services and/or notification to your physician and insurance carrier.

Regular attendance and active participation in your therapy program is necessary for you to get the maximum benefit from our services. It is also important for you to have open communication with your therapist about the therapy being provided and any pain you might be experiencing so that therapy can be adjusted to meet your needs.

If you have any questions regarding our services, please call our office at 916-782-1217.

We look forward to working with you.

Sincerely,

James E. Eaton, MSPT

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Patient Notice

You are being referred for physical services. You may seek therapy services from a therapist of your choice who may or may not be employed by Roseville Orthopedic Surgery & Sports Medicine. If you choose to be treated by a therapist employed by Roseville Orthopedic Surgery & Sports Medicine, please be aware that your physician has a financial interest in Roseville Orthopedic Surgery & Sports Medicine and its therapy clinic.

Please note also that while we believe it is proper you are notified of this relationship and your ability to work with other therapists, we also believe you benefit from the close working relationship we have with the therapists at Roseville Orthopedic Surgery and Sports Medicine and from our ability to ensure that the therapists treating you are among the highest quality therapists available.

Please acknowledge your receipt of this notice by signing and dating this notice below.

_____

Patient Signature

_____

Printed Patient Name

_____

Date Signed

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CONSENT FOR TREATMENT

Patient's Name: _____ Date: _____

I hereby authorize the therapists at Roseville Orthopedic Physical Therapy to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

_____

(Authorized Signature) (Date)

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*** This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. ***

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS TO PROVIDERS & INSURANCE COMPANIES

I hereby authorize this Practice to release any and all medical records concerning my care to any insurance company, physician, hospital or other healthcare professional providing care to me at any time.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

_____ _____
Patient/Guardian Signature Date

_____ _____
Print Name Date of Birth

In compliance of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your physician or staff members to discuss your condition with members of your family or any other person that you designate, we must obtain your permission prior to doing so. In the event that you are unable to give your authorization due to a medical condition, the law stipulates that these rules may be waived.

____ I do not authorize the Practice to release any or all information concerning my health care to any individual.

____ I authorize the Practice to release any or all information concerning my medical care to the following individuals.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

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Rehabilitation Screening/Confidential Medical History

Patient's Name: _____ **Age:** _____ **Date:** _____

Please complete the following questions to the best of your ability. This will help us to develop a treatment with you that meets your individual needs.

1. Date of injury or when problem last caused you to seek medical attention: _____

2. How did your current problem begin? ❑ lifting ❑ twisting ❑ falling ❑ motor vehicle accident ❑ unknown ❑ other: _____

3. Were you hospitalized for this problem? ❑ yes ❑ no If yes, give dates: _____

4. Are you currently being seen by any of the following? ❑ dentist ❑ chiropractor ❑ osteopath ❑ physical therapist ❑ occupational therapist ❑ psychiatrist/psychologist ❑ home health
If you are seeing any of the above, please describe the reason: _____

5. Are you presently working? ❑ yes ❑ no Occupation? _____
If working, is it ❑ light/modified duty ❑ regular duty?

6. Are you ❑ right or ❑ left handed?

7. Do you use a: ❑ cane ❑ walker ❑ other: _____ ❑ none

8. What type of exercise are you currently doing? _____

9. Do you currently experience any of the following?

❑ Cardiac Problems	❑ Diabetes	❑ Hypertension
❑ Orthopedic Problems	❑ Rheumatoid Arthritis	❑ GI problems
❑ Cancer	❑ Seizures	❑ Multiple Sclerosis
❑ Fibromyalgia	❑ Depression	❑ Drug/Alcohol Dependency

10. Have you ever had a broken bone or fracture? ❑ yes ❑ no If yes, which body part: _____ When: _____

11. Do you smoke? ❑ yes ❑ no If yes, number of packs/day? _____

12. Are you pregnant? ❑ yes ❑ no

13. List any medication allergies _____

14. List all prescription or over-the-counter medications you are currently taking **if you have not currently provided this information already:**

_____
_____
_____

15. What are your goals of therapy?

_____

Medicare patients only:

1. Have you had physical, occupational or speech therapy any time this year? ❑ yes ❑ no

2. Have you fallen at least once in the past year and sustained an injury? ❑ yes ❑ no If yes, please explain:

_____

3. Have you fallen at least twice in the past year without injury? ❑ yes ❑ no

4. How would you describe your overall health? ❑ excellent ❑ good ❑ fair ❑ poor

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Patient Instructions for Completing the Functional Outcome Questionnaire

Roseville Orthopedics Physical Therapy would like to thank you for completing the following questionnaire. The questionnaire is designed to help your therapist set personal goals for your rehabilitation program, communicate progress to your physician and improve the quality of the care that is provided to you. Please read through the following specific instructions in order to complete this questionnaire.

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1. If you are unsure as to how to answer any specific question, please ask your therapist during your evaluation.
2. Answer all questions based on your ability to perform the activity with your involved or "bad" hand, arm, leg or foot.
3. Please do not answer according to your ability to adapt and do with the other or "good" hand, arm, leg or foot.
4. Answer all questions based on how your present condition has changed your ability to perform these activities.
5. If any factor (such as pain, weakness, unsteadiness, bracing or casting) is affecting your ability to perform any of the activities in the questions, then that specific question should not be scored as normal.
6. If any question is not related to your present condition, please score as N/A.
7. Please rate your pain level before you take any pain medication.

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient Name:_____ Age:_____ Gender:_____ Number of Visits:_____

Using the key below please circle one answer in each box that indicates your ability to do the following activities;

Key: (0 = unable) (1 = very difficult) (2 = moderately difficult) (3 = minimally difficult) (4 = normal) (N/A = not applicable to your current condition)

Activity	Score					
1. Sleep normally	0	1	2	3	4	N/A
2. Up and Down Stairs	0	1	2	3	4	N/A
3. Food Prep/Cooking/Eating	0	1	2	3	4	N/A
4. Walking	0	1	2	3	4	N/A
5. Grooming (bath, comb hair, shave, etc)	0	1	2	3	4	N/A
6. Getting up/down from chair or bed	0	1	2	3	4	N/A
7. Dressing – manage normal dressing activities	0	1	2	3	4	N/A
7a: Dressing – Tie Shoes/Button Shirt	0	1	2	3	4	N/A
8. Lifting/Carrying up to 10 pounds	0	1	2	3	4	N/A
9. Sitting for normal periods of time	0	1	2	3	4	N/A
10. Standing for normal periods of time	0	1	2	3	4	N/A
11. Reaching above head or across body	0	1	2	3	4	N/A
12. Leisure/Recreational/Sports Activities	0	1	2	3	4	N/A
13. Squatting down to pick up item	0	1	2	3	4	N/A
14. Running/Jogging	0	1	2	3	4	N/A
15. Driving	0	1	2	3	4	N/A
16. Job Requirements – can do all activities required of my job	0	1	2	3	4	N/A

Pain Scale - Please circle the number that describes the pain you have experienced over the last week with 0 being no pain and 10 being the worst imaginable – **WHEN NOT TAKING PAIN MEDICATION**.

0	1	2	3	4	5	6	7	8	9	10

FOR OFFICE USE ONLY

Group Name/Location: Roseville Orthopedics PT or OT Evaluation or Discharge Date: _____

Region (use key) _____ Diagnosis (use key)_____

Therapist Name: Jim / Julie / Jack / Laura / _____ ACS 4-16