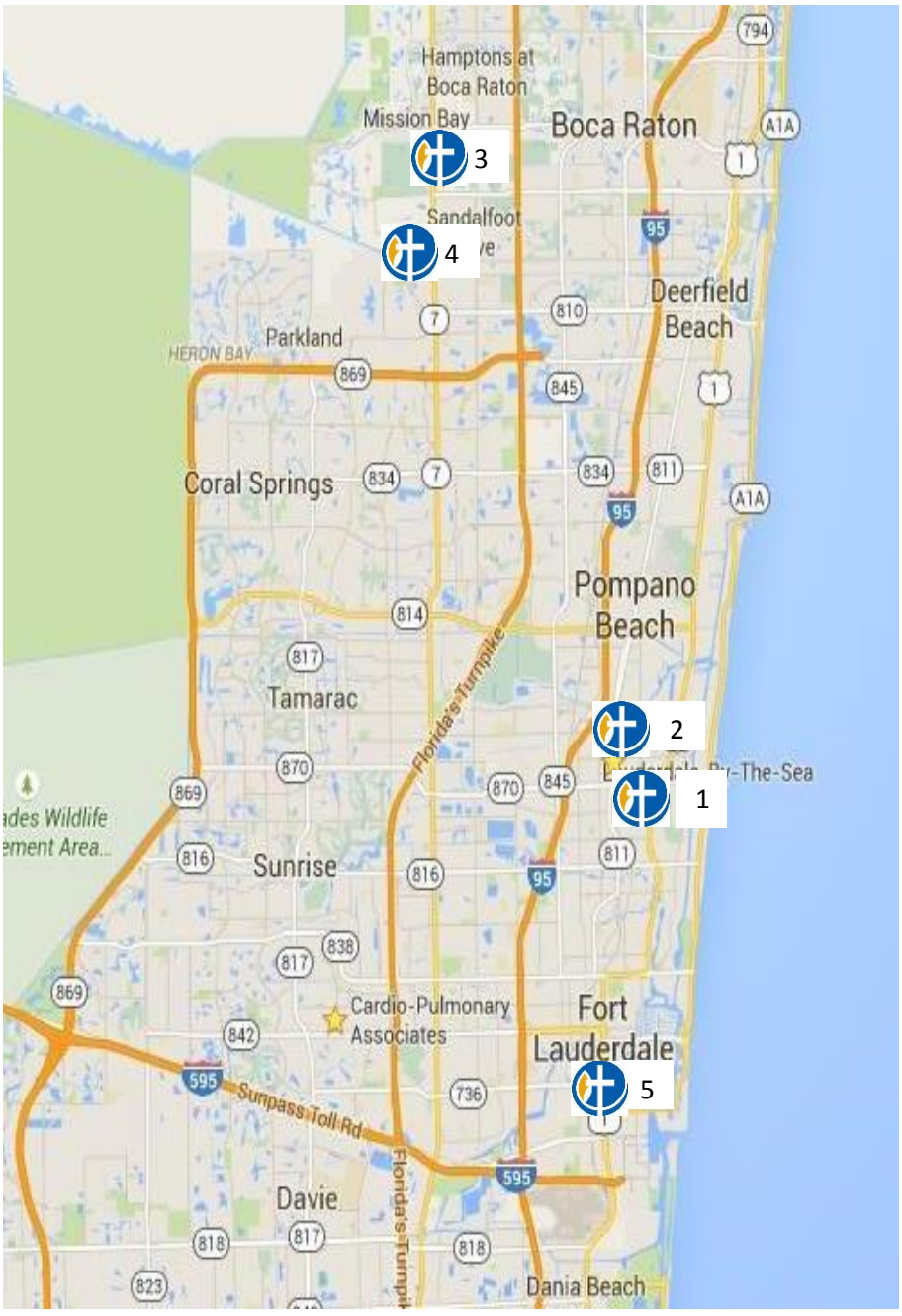
Thank you for choosing Holy Cross Outpatient Rehabilitation

- Please complete the attached paperwork prior to your arrival.
- Ensure you know which facility you are scheduled for.
- Please arrive 20 minutes prior to your scheduled appointment time to complete registration.
- If you have any questions please contact the facility



(1) Holy Cross Main Hospital PT/OT/Speech
4725 N Federal Highway
954-492-5738 F: 954-776-3096
Corner of Commercial Blvd

(2) HCMG Orthopedic Institute Holy Cross HealthPlex - PT/OT/Hand
5597 North Dixie Highway
954-267-6390 F: 954-267-6398
Between Commercial & Cypress Creek

(2) Women's Health Rehab Dorothy Mangurian Comprehensive Women's Center - PT
1000 NE 56th Street
954-229-8685 F: 954-229-8692
Off Dixie north of Commercial Blvd

(3) HCMG Ortho Institute West Boca PT/OT/Hand
9970 Central Park Blvd #400A
Boca Raton
561-483-6924 F: 561-852-1997
North of Palmetto

(4) West Boca Raton Urgent Care PT
23071 State Road 7 (441) Boca Raton
561-477-6012 F: 561-488-3508

(5) HCMG Rio Vista PT
1309 S Federal Highway
954-267-6819 F: 954-776-3096
South of Davie Blvd, N of I-595

Holy Cross Home Health
954-267-7000

(1) Zachariah Wellness Pavilion
954-229-7950

Name: _____ Date: _____

Date of onset of: ❑ Injury ❑ Problem ❑ Surgery _____

State your main reason for therapy: _____

Do you now have, or have you ever had any of the following?

High Blood Pressure	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No	Seizures	❑ Yes	❑ No
Dizziness/Fainting	❑ Yes	❑ No	Fractures	❑ Yes	❑ No
Osteoporosis	❑ Yes	❑ No	Circulatory Problems	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Recent Weight Change	❑ Yes	❑ No
Bowel/Bladder Problems	❑ Yes	❑ No	Swallowing Problems	❑ Yes	❑ No
Kidney Problems	❑ Yes	❑ No	H/O Falls	❑ Yes	❑ No
Stroke/Mini Stroke	❑ Yes	❑ No	Hip Replacement	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No	Knee Replacement	❑ Yes	❑ No
Heart Problems	❑ Yes	❑ No	Other	❑ Yes	❑ No

If **YES** to any of the above, please explain: _____

_____

_____

Please list any other significant medical diagnoses or conditions:_____

_____

_____

Please list any previous surgical, operative or invasive procedures that you have had: _____

_____

_____

Please list any medications including long term, current, over-the-counter or herbal preparations that you are currently taking:

_____

_____

Please describe any known adverse and allergic drug reactions: _____

_____

Is this problem related to a motor vehicle accident? ❑ Yes ❑ No If **YES**, when? _____

Have you had this problem before? ❑ Yes ❑ No If **YES**, when? _____

If YES, did you receive therapy for this problem? ❑ Yes ❑ No If **YES**, what treatment helped you? _____

_____

Has this problem limited your ability to perform everyday task? ❑ Yes ❑ No If **YES**, what are they? _____

_____

What are your goals for therapy? Be specific: _____

_____

PATIENT INFORMATION – REHABILITATION SERVICES

PAIN SCREEN

1. Do you have pain now? ❑ Yes ❑ No

2. If no, have you had pain in the last 24 hours or past few days, weeks or months? ❑ Yes ❑ No

If the answer is **NO** to both questions, **STOP NOW!**

If the answer is YES to either question, continue below:

3. Is the pain you are experiencing of related to your **current reason** for therapy? ❑ Yes ❑ No

If the answer to question #3 is **YES**, complete the INITIAL PAIN ASSESSMENT.

INITIAL PAIN ASSESSMENT	Location 1	Location 2	Location 3	Location 4
Location: Where do you have pain?				
Quality: What does your pain feel like for each location? (throbbing, tender shooting, stabbing, sharp, cramping, burning, aching, heavy, etc.)				
Intensity: On a scale of 0-10 with 0 being "no pain" and 10 being the "worst pain ever," Rate your pain as it feels now.				
Rate your pain at its best: (0-10)				
Rate your pain at its worst: (0-10)				
What is your goal for pain intensity?				
Time/Frequency: When did the pain start?				
Is the pain **constant** (always there) or **intermittent** (comes and goes)?				
What positions, situations help **alleviate** (ease) your pain?				
What activities or situations **aggravate** or makes your pain worse?				

What alternative therapies have you tried? ❑ NONE ❑ Cold ❑ Heat ❑ Massage

❑ Other: _____ What works well? _____ Works poorly? _____

All of this information has been reviewed with the patient and/or family: ❑ Yes

_____ _____

Signature of Person Completing Form Date

_____ _____

Staff Signature Date

Low Back Oswestry Pain Disability Questionnaire

Name:_____ Date:____/____/_____ Score:_____

This questionnaire is designed to help your Physical Therapist understand how much your low back pain has affected your ability to manage in everyday life. Please answer each section and mark only **ONE BOX** which best applies to you at this moment.

PAIN INTENSITY

□The pain comes and goes and is very mild.
□The pain is mild and does not vary much.
□The pain comes and goes and is moderate.
□The pain is moderate and does not vary much.
□The pain comes and goes and is severe.
□The pain is severe and does not vary much.

PERSONAL CARE

□I would not have to change my way of washing or dressing in order to avoid pain.
□I do not normally change my way of washing or dressing even though it causes some pain.
□Washing and dressing increase the pain, but I manage not to change my way of doing it.
□Washing and dressing increase the pain and I find it necessary to change my way of doing it.
□Because of the pain, I am unable to do some washing and dressing without help.
□Because of the pain, I am unable to do any washing or dressing without help.

LIFTING

□I can lift heavy weights without extra pain.
□I can lift heavy weights, but it causes extra pain.
□Pain prevents me from lifting heavy weights off the floor.
□Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
□Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
□I can only lift very light weights at the most.

WALKING

□I have no pain walking
□I have some pain walking but it does not increase with distance
□I cannot walk more than 1 mile without increasing pain
□ I cannot walk more than ½ mile without increasing pain
□I cannot walk more than ¼ mile without increasing pain
□I cannot walk at all without increasing pain

Low Back Oswestry Pain Disability Questionnaire

SITTING

□I can sit in any chair as long as I like
□I can only sit in my favorite chair as long as I like
□Pain prevents me from sitting more than 1 hour
□Pain prevents me from sitting more than ½ hour
□Pain prevents me from sitting more than 10 minutes
□I avoid sitting because it increases pain immediately

STANDING

□I can stand as long as I want without pain
□I have some pain while standing, but it does not increase with time
□I cannot stand for longer than one hour without increasing pain
□I cannot stand for longer than ½ hour without increasing pain
□I can't stand for more than 10 minutes without increasing pain
□I avoid standing because it increases pain right away

SLEEPING

□I get no pain in bed
□I get pain in bed, but it does not prevent me from sleeping well
□Because of pain , my normal night's sleep is reduced by less than one-quarter
□Because of pain, my normal night's sleep is reduced by less than one-half
□Because of pain, my normal night's sleep is reduced by less than three-quarters.
□Pain prevents me from sleeping at all.

SOCIAL LIFE

□My social life is normal and gives me no pain
□My social life is normal, but increases the degree of my pain
□Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
□Pain has restricted my social life and I do not go out very often
□Pain has restricted my social life to my home
□I have hardly any social life because of the pain

TRAVELING

□I get no pain while traveling.
□I get some pain while traveling, but none of my usual forms of travel make it any worse.
□I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
□I get extra pain while traveling which compels me to seek alternative forms of travel.
□Pain restricts me to short necessary journeys under ½ hour.
□Pain prevents all forms of travel.

CHANGING DEGREE OF PAIN

□My pain is rapidly getting better.
□My pain fluctuates, but overall is definitely getting better.
□My pain seems to be getting better, but improvement is slow at present.
□My pain is neither getting better nor worse.
□My pain is gradually worsening.
□My pain is rapidly worsening