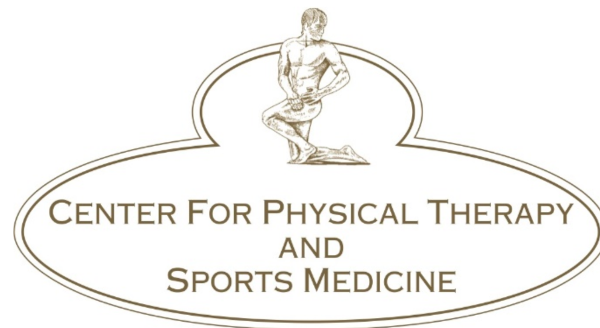

Physical Therapy Instructions and Information

1**. The Center for Physical Therapy and Sports Medicine is located next door in Building A. It is owned and operated by the physicians of Georgia Bone and Joint Surgeons, P.C.,** and is staffed by licensed Physical Therapists, Physical Therapist Assistants, and trained Physical Therapy Technicians.

2. You have the right to have therapy at the place of your choosing. We thank you for choosing us for your therapy needs.

3. In order to allow for sufficient time for new patient registration, **please arrive 15 minutes prior to your appointment time.**

4. **Please complete the following forms and bring them to your appointment.**

5. The initial therapy visit will last approximately one hour.

6. Proper attire is essential. Please dress in clothing that allows access to the body part being treated. For example, for hip, knee, or ankle problems, please wear or bring shorts. If being treated for shoulder, neck, or upper back, please wear a loose fitting short sleeve shirt. If your low back or spine is the issue, please wear or bring shorts and a loose fitting shirt. Tennis shoes should be worn to all visits.

7. Due to patient confidentiality and for the comfort of all patients, family members are not allowed in the therapy treatment areas unless special assistance is needed and/or the patient is a minor.

8. If your insurance requires a copay, it will be collected at each visit. Please bring your method of payment with you to each visit.

9. Please feel free to contact us at 770-382-5621 with any questions.

Patient Self Evaluation Form

Name: ____ Date: _____________

The purpose of this form is to assist you in identifying and clarifying your problem areas and discovering your present level of awareness of your body. It will also serve as a means to acknowledge and note what changes result from the treatments. Please be as complete and in-depth as possible. The privacy of your answers will be respected. The use of this form or the answering of any question is optional.

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1. **<u>Present Condition: Pain or Tension</u>**

   a. What are the present symptoms of the problems(s) for which you are seeking treatment?

      Location:

      Frequency:

      Type:

   b. Circle the number indicating your pain level:

      Current: 0 1 2 3 4 5 6 7 8 9 10

      Highest: 0 1 2 3 4 5 6 7 8 9 10

      No pain … Unbearable pain

   c. What makes your symptoms worse?

   d. What makes your symptoms better?

   e. Are you taking any medications? What? How much?

   f. What does this pain keep you from doing?

   g. What do you think initially caused your symptoms? When?

2. **<u>Current history of complaint</u>**

   a. Have you ever had anything similar before?

   b. How often has it reoccurred?

   c. Is the frequency or severity increasing?

3. **<u>Postural Concerns</u>**

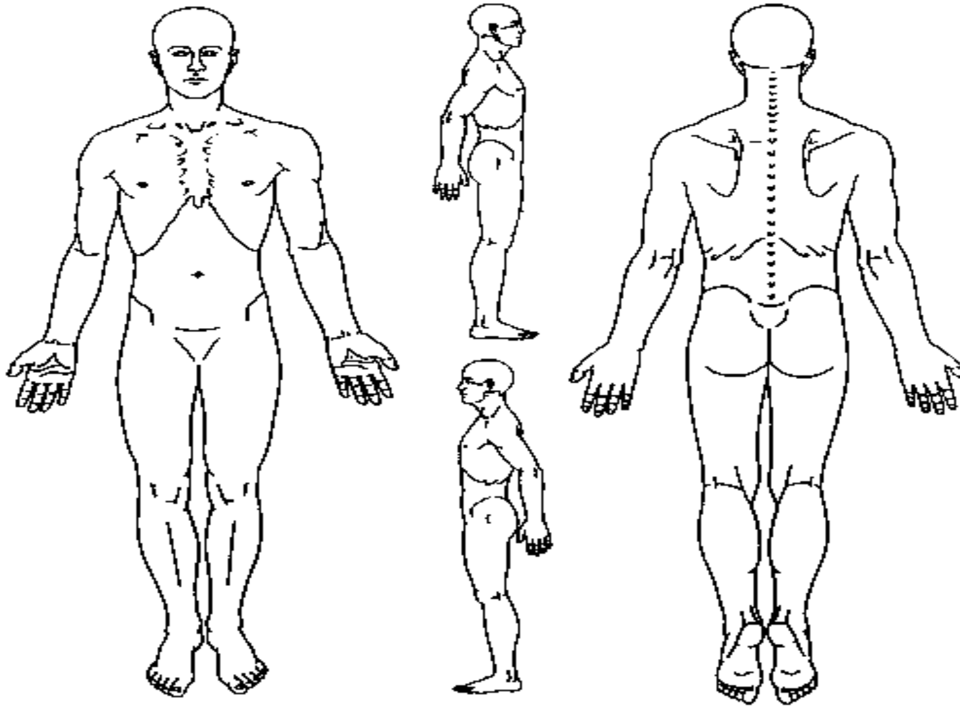
   a. Do you experience any problems with your posture or movement?

   b. Do you feel this is a result of pain, tension, previous injury, and/or habit patterns?

   c. Do you feel this problem limits your daily activities?

4. **<u>Please draw on the picture below any pain or symptoms you have using the following symbols:</u>**

A = ACHE	**B** = BURNING	**O** = OTHER
P = PINS & NEEDLES	**N** = NUMBNESS	R = RADIATING



5. **<u>Past Medical History (Note briefly any previous)</u>**
   a. Accidents or injuries:

   b. Surgeries:

   c. Do you have any other diagnosed problems? Birth defects?

   d. Are you currently under the care of another physician, psychiatrist, or health professional? Whom?

   e. Have you received any previous physical therapy, chiropractic care, or massage therapy? How long ago?

6. **<u>What goals do you want to achieve with physical therapy?</u>**

7. **<u>What do you expect from physical therapy?</u>**