OPTIMOVE
Physical Therapy and Wellness

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1. Client Name: _____ Client Date of Birth: _____

Primary Care Physician: _____

Physician's Phone Number: _____ Physician's FAX Number: _____

Other Healthcare Provider: _____ Type of Provider: _____

Other Healthcare Provider's Phone Number: _____ Other Healthcare Provider's FAX Number: _____

2. Please check if you have ever experienced or been treated for any of the following health conditions and the date when it occurred (or date diagnosed):

	Yes	Date(s)
Anemia		
Cancer		
Heart Disease		
Liver Disease		
Heart Attack		
Ulcers		
Migraines		
Asthma		
Pacemaker		
Diabetes		
Vertigo		
Fractures		
High Blood Pressure		
Kidney Disease		
Stroke		
Depression		
Allergies		
Polio		
Car accident		
Pregnancy		
Hospitalization		
Sudden Dizziness		

If fractures, please specify:

_____

3. Please list any past surgeries with dates:

	Surgeries	Dates
1		
2		
3		

4. Please list your date of injury (if applicable) or duration of current symptoms:

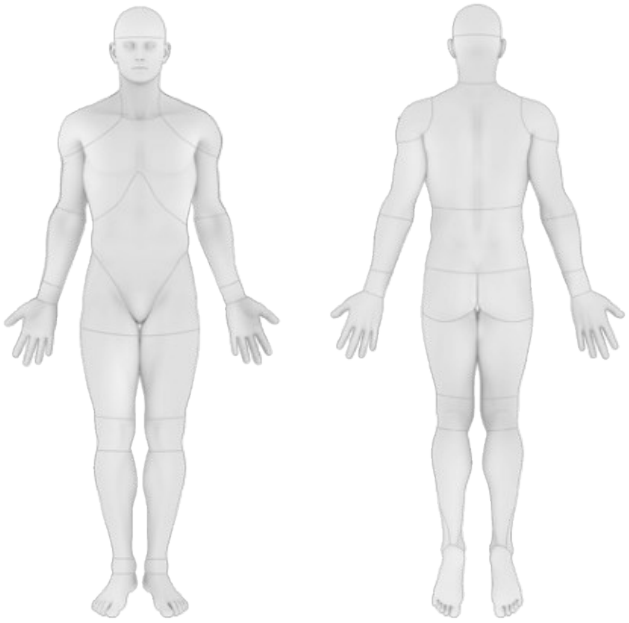
	Injury	Date	Current Symtpms
1			
2			
3			

5. Please list any medications you are currently taking:

6. Please describe your symptoms:

7. What is your desired outcome from physical therapy?

8. Please indicate your location of pain on the diagram below:



9. Please indicate where your pain level is (0=none, 10=emergency room pain):

Healthcare Decision-Making Questionnaire

10. How do you go about managing your medical care?

11. Would you like someone else to also be involved in this care?

- ○ Yes
- ○ No

12. If so, who?

Name: | Relationship: | Contact Number:

13. Does anyone help you make your medical decisions?

- ○ Yes
- ○ No

14. If so:

Who is that person: | Should we bring that person in?

15. Do you have a medical power of attorney?

- ○ Yes
- ○ No

16. If so:

Relation to them: | Contact Number:

17. Do you have a financial power of attorney?

- ○ Yes
- ○ No

18. If so:

Relation to them: | Contact Number:

19. Would you or anyone representing you like to receive monthly or quarterly reports about this plan of care?

- ○ Yes
- ○ No

If so, to whom should we send it?

_____

20. Please provide the following information about your Emergency Contact:

_____

_____

_____

21. Do you think you are suffering from any cognitive or memory problems?

_____

_____

_____

_____

22. Have you ever been declared mentally incapacitated by a court of law?

_____

_____

_____

_____