RIVERSIDE Medical Center
REHABILITATION SERVICES

Medical Center	Atrium	Health Fitness Center	Manteno	Wilmington
350 N. Wall Street Kankakee	400 S. Kennedy Bradley	100 Fitness Drive Bourbonnais	395 N. Locust Manteno	105 S. First Street Wilmington
(815) 935-7514 Fax (815) 935-7069	(815) 935-7496 Fax (815) 935-7860	(815) 928-8324 Fax (815) 928-9972	(815) 468-8246 Fax (815) 468-8648	(815) 476-5210 Fax (815) 476-1080

Thank you for choosing Riverside Rehab Services Physical Therapy, Occupational Therapy, and/or Speech therapy for your treatment. Please fill out the forms in this packet prior to your first therapy session with us and bring them to your first appointment. Read all of the material and complete the forms to the best of your ability. Leave blank any areas you may need help with or have questions on. The forms are intended to provide your caregivers with accurate information about your back pain and overall health.

Your First Visit

For your first visit, please arrive 15 minutes early to be registered into our computer system. Please bring the following with you:

1. This packet filled out
2. Your prescription for therapy
3. Your insurance card
4. A picture ID
5. Your appointment calendar to schedule follow up visits

Wear comfortable clothes and shoes. The therapist typically spends 30 minutes to 1 hour completing your initial evaluation. If you are coming for multiple services, expect 45 minutes with each care provider.

Call 815-935-7514 if you have any questions prior to your first visit.

Thank you for choosing Riverside.

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Riverside Medical Center
Outpatient Rehabilitation Services and Sports Medicine
Questionnaire:

Name _____ Date _____

Diagnosis _____

Occupation _____ Age _____

Are you currently working? Full Duty_____ Light Duty_____ No _____

MEDICAL HISTORY:

Cardiac Problems	YES____	NO____	explain: _____		
High Blood Pressure	YES____	NO____			
Cardiac Pacemaker	YES____	NO____	Asthma:	YES____	NO____
Joint Replacements	YES____	NO____	Diabetes:	YES____	NO____
History of cancer	YES____	NO____	Pregnant:	YES____	NO____
Shortness of breath	YES____	NO____			
History of seizures	YES____	NO____			
Metal Implants	YES____	NO____			

What medications are you currently taking? _____

_____

What allergies do you have? _____

_____

List all past/present surgical procedures: _____

_____

List any other medical problems not mentioned above: _____

_____

Describe your current reason for attending therapy: _____

_____

1. Have you been discharged from care under any of the following providers in the past 30 days? (Circle if applicable): Hospital Skilled Nursing Facility Home Health
2. Have you ever been treated for this condition previously? Yes___ No___ If yes, please explain _____

   _____
3. At present time would you say that your health is (Please Circle One):
   Excellent Very Good Good Fair Poor

Answer the following based on your current condition:

How and when did this start? _____

Where is your pain located? _____

What makes your pain/condition worse? _____

What makes your pain/condition better? _____

Rate your pain on a scale from 0 (no pain) to 10 (worst pain ever) _____

What are you unable to do because of your pain/problem? _____

Do you have any "pins and needles" or numbness? _____

Is your pain a: Throb _____ Twinge _____ Burning _____ Other _____

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Attendance Policy

Thank you for choosing Riverside for your outpatient therapy needs. We are committed to providing you with very good care and want you to have the best experience possible with your therapy.

In order for you to experience the highest benefit from your therapies, it is very important that you attend your therapy sessions as prescribed by your doctor and therapist. Frequent absenteeism and non-participation in therapy will affect your ability to receive maximum benefit from your therapy. We ask that you abide by the following attendance policy to ensure we can give you the very best care and maximize your health improvements with our therapies:

- Attend your therapy sessions as scheduled. If you are unable to attend we request 24 hours notice of a cancellation. Every attempt will be made to reschedule your appointment for the same day or at your next available convenience.

- Your doctor will be notified after 3 consecutive "No Show" absences or inconsistent attendance and you will be discharged from therapy services.

- Chronic cancellations and "No Shows" are reasons for discharge from therapy.

- Our staff will work with you to find the best appointment time for your schedule. We respect your time and the time commitment involved to attend therapy throughout the week, please respect the times we have reserved for you to attend.

We have established this policy to offer our patients ample opportunities to receive care while being respectful of the time commitment involved for all parties.

If you have questions about this policy, please talk to the receptionist at the front desk.

Thank you,

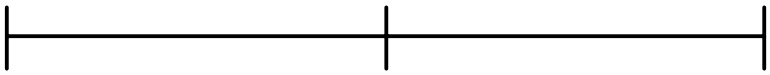
Patient Signature _____ Date: _____

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.



I have *extreme difficulty* doing any of the activities that I would like to do.

I have *no difficulty* doing any of the activities that I would like to do.

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.____

Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther*. 2005;85:515-530.

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
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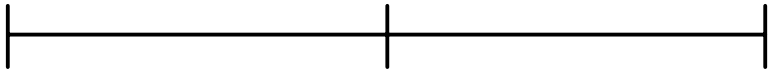
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

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:



I have *no confidence* that I can do activities that I would want to do.

I have *complete confidence* that I can do activities that I would want to do.

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