RIVERSIDE Medical Center
REHABILITATION SERVICES

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

Thank you for choosing Riverside Rehab Services Physical Therapy or Occupational Therapy for treatment of your back/spine. 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.

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

Thank you for choosing Riverside.

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,

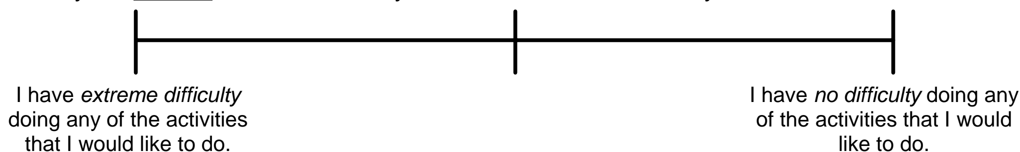
Patient Signature ________________________________ Date: ___________

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.____

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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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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* 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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Modified Oswestry Low Back Pain Questionnaire

Patient Name: ______________________________ **Date:** __________________

How long have you had back pain? ______________________ **How long have you had leg pain?**___________________

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section one box only which applies to your status today. We realize you may consider that 2 of the statements in any one section may relate to you, but please mark the one box which most closely describes your problems.

Section 1 – Pain Intensity (Check one answer)

- ❑ I can tolerate the pain I have without having to use pain killers.
- ❑ The pain is bad, but I manage without taking pain killers.
- ❑ Pain killers give complete relief from the pain.
- ❑ Pain killers give moderate relief from the pain.
- ❑ Pain killers give very little relief from the pain.
- ❑ Pain medication have no effect on the pain and I do not use them.

Section 2 – Personal Care (washing, dressing, etc.) (Check one answer)

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes me extra pain.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help, but manage most of my personal care.
- ❑ I need help every day in most aspects of self care.
- ❑ I do not get dressed, I wash with difficulty, and I stay in bed.

Section 3 – Lifting (Check one answer)

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it causes me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can mange light to medium weights if they are positioned conveniently.
- ❑ I can only lift very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking (Check one answer)

- ❑ Pain does not prevent me from walking any distance
- ❑ Pain does not prevent me from walking more than 1 mile.
- ❑ Pain prevents me from walking more than ½ mile.
- ❑ Pain prevents me from walking more than ¼ mile.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Modified by Fritz & Irrgang with permission of The Chartered Society of Physiotherapy from Fairbanks JCT, Couper J, Davies JB, et al. The Oswestry Low Back Pain Disability Questionnaire. Physiotherapy. 1980;66:271-273.

Section 5 – Sitting (Check one answer)

- ❑ 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 for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing (Check one answer)

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want, but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing more than ½ hour.
- ❑ Pain prevents me from standing more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping (Check one answer)

- ❑ Pain does not prevent me from sleeping well.
- ❑ I can sleep well only by using pain killers.
- ❑ Even when I take pain killers, I have less than 6 hours sleep.
- ❑ Even when I take pain killers, I have less than 4 hours sleep.
- ❑ Even when I take pain killers, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Social Life (Check one answer)

- ❑ My social life is normal and gives me no extra pain.
- ❑ My social life is normal, but increases the degree of 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.
- ❑ Pain prevents any social life at all.

Section 9 – Traveling (Check one answer)

- ❑ I can travel anywhere without extra pain.
- ❑ I can travel anywhere, but it gives me extra pain.
- ❑ Pain is bad, but I manage journeys over two hours.
- ❑ Pain restricts me to journeys of less than one hour.
- ❑ Pain restricts me to short, necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Employment/Homemaking (Check one answer)

- ❑ My normal homemaking/job activates do not cause pain.
- ❑ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ❑ I can perform most of my homemaking / job duties, but pain prevents me performing more physically stressful activities (ex. Lifting, vacuuming).
- ❑ Pain prevents me from doing anything but light duties.
- ❑ Pain prevents me from doing even light duties.
- ❑ Pain prevents me from performing any job or homemaking chores.

Comments ____