Physical Therapy & Feldenkrais NYC

First Name	Last Name	Date of Birth
Street Address	City & State, Zip Code	Email
Male Female	Marital Status	Height Weight
Home Phone	Work Phone	Cell Phone
Occupation/Employer	Level of control over work conditions: High Medium Low	Satisfaction & Fulfillment with work: High Medium Low
Emergency Contact – Name	Emergency Contact - Relationship	Emergency Contact – Phone
Referring Doctor	When do you next see your doctor?	Do you have a prescription?
How did you hear about us?	Would you like to receive email re: upcoming workshops/ events at the Feldenkrais Institute? Yes No	Have you received physical therapy in the last year? If so, how many visits?

What problem are you treating for today?
Approximately when did your symptoms begin?
Describe any change in your condition from one month ago: Much better Somewhat better Same Somewhat worse Much worse
What treatments do you receive for this condition?

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Participating Member of the Hospital for Special Surgery Rehabilitation Network

What makes your symptoms better?
What makes your symptoms worse?
What is your goal for therapy?
Life's stresses & tensions: high stress moderate stress low stress
Diet: very healthy moderately healthy not healthy
Alcohol intake per week:
Smoking: daily occasionally no
Is there anything else we should know that is pertinent to your treatment?
Health history (briefly describe & include any chronic conditions and surgeries):

Office Policies:

- Payment is due at the time of service.
- We recommend scheduling 4 – 6 weeks in advance. We can also put your name on our waiting list and we will notify you when an appointment becomes available.
- Cancellation Policy: **We require 24 HOUR NOTICE for any cancellations** as we reserve the full hour appointment time exclusively for you and would like the opportunity to offer the appointment to a wait-listed client if you need to cancel. Please allow ample time for public transportation or inclement weather. **A $155 cancellation fee will be applied to appointments cancelled or broken without 24 hour notice.**
- About the Feldenkrais Method: Feldenkrais is a movement-based method of learning. Our physical therapists are Guild Certified Feldenkrais practitioners who, based on the initial evaluation, may incorporate principles of the Feldenkrais Method to help clarify postural alignment, patterns of movement and self-use through verbal instruction or gentle hands-on work. The practitioner may work with areas of the body other than the specific site of injury or pain. If you experience discomfort, physical or otherwise, please inform the therapist without delay. Your comfort is a necessary condition for learning more optimal ways of moving and the overall success of the treatment.
- For clients not seeking physical therapy, please note that Feldenkrais lessons are not reimbursable by insurance.

TREATMENT AUTHORIZATION: I have entered all the above information to the best of my knowledge. I have read and understand the office policies.

SIGNATURE: DATE:

CONSENT FORM

1. I understand that Physical Therapy & Feldenkrais NYC, PC (the "Practice") does not bill insurance companies and that I am solely responsible for understanding my deductibles and co-insurance and for seeking reimbursement from my insurance provider.

2. I consent to the use of photography and/or video recordings as a component of my treatment. These will be used only as necessary for my plan of care, and I will be made aware that these photos and/or videos are being taken. These photos and video recordings are part of my medical record and will not be reproduced or used otherwise, without my written consent. I can refuse to have photos and/or videos taken without any change in my care at the Practice. Copies of the photos and/or videos may be released to me upon my request.

3. By my signature below, I consent to the use or disclosure of my health information in order that the Practice may carry out treatment, payment or health care operations. For purposes of this consent, health information shall mean any and all information relating to health care services provided to me by the Practice, including, without limitation, information relating to services provided to me prior to this date. Unless requested in writing, the Practice will not disclose protected health information to patients' relatives or friends.

4. I understand that if I refuse to sign this consent, or if I revoke this consent in the future, the Practice will not provide any treatment to me or arrange for treatment on my behalf, and may discharge me as a patient to the extent permitted by the law.

5. I have read this form and certify that I understand its contents as of this date.

Print Name: _____

Signed: _____ Dated: _____

OPTIMAL INSTRUMENT

Name: _____

Difficulty–Baseline

Date: _____

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.

Patient Name: _____

LIST OF CURRENT MEDICATIONS

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How and How Often You Take the Medication	Reason for Taking	Date Started	Prescriber

Reviewed by: _____