

PATIENT INFORMATION

FIRST NAME: _____ MI: _____ LAST NAME: _____ DATE: _____
NOMBRE INICIAL APELLIDO FECHA

DATE OF BIRTH: _____ SOC SEC #: _____ SEX: FEMALE MALE
FECHA DE NACIMIENTO SEGURO SOCIAL SEXO FEMENINO MASCULINO

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
DIRECCION CIUDAD ESTADO CODIGO POSTAL

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
ELEFONO DE CASA TELEFONO DE TRABAJO TELEFONO CELLULAR

E-MAIL
CORREO ELECTRONICO _____

EMPLOYER: _____ OCCUPATION: _____
EMPLEADOR POSICION

EMERGENCY
CONTACT _____ **PHONE:** _____ **RELATIONSHIP:** _____
CONTACTO DE EMERGENCIA TELEFONO PARENTESCO

REFERRING DR./PRIMARY DR: _____ **PHONE:** _____
DOCTOR QUE LO REFIERE/MEDICO DE CABECERA TELEFONO

LANGUAGE PREFERENCE: _____

GUARANTOR & PARTY RESPONSIBLE FOR BILL

FIRST NAME: _____ MI: _____ LAST NAME: _____ RELATIONSHIP: _____
NOMBRE INICIAL APELLIDO PARENTESCO

DATE OF BIRTH: _____ SOC SEC#: _____ SEX: FEMALE MALE
FECHA DE NACIMIENTO SEGURO SOCIAL SEXO FEMENINO MASCULINO

ATTORNEY NAME: _____ PHONE NUMBER: _____

INSURANCE INFORMATION

MEDICARE MEDICAID AUTO WORKERS COMP COMMERCIAL SELF PAY

PRIMARY INSURANCE: _____
SEGURO PRIMARIO

SECONDARY INSURANCE: _____
SEGURO SECUNDARIO

ATTORNEY NAME: _____

DISCLAIMER AND INFORMED CONSENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
I hereby request and authorize **Physical Therapy Institute and Aquatic Rehab, Inc./ Royal Palm Beach Rehab, Corp. / Action Physical Therapy, LLC.** To perform diagnostic tests and give treatment as deemed necessary. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give consent to that treatment.

PATIENT'S SIGNATURE _____ **DATE** _____
FIRMA DEL PACIENTE FECHA

WITNESSED BY _____ **DATE** _____
ATESTIGUADO POR FECHA

If the patient is a minor, permission is hereby given by me to the doctors of this office and whomever they designate to treat The patient. I am the patients' legal guardian.

GUARDIAN'S SIGNATURE _____ **DATE** _____
FIRMA DEL REPRESENTANTE LEGAL

Patients Name: _____

Patients Height: _____

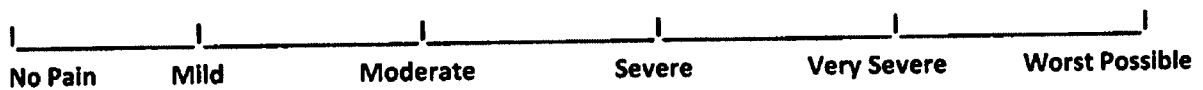
Patients Weight: _____

BMI: _____

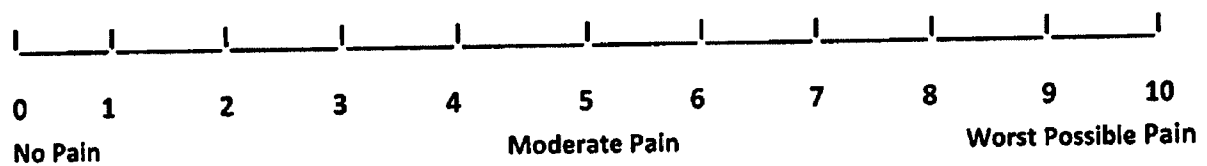
Medication List: (Please list ALL of the medications you are currently taking)

Medication Name	Dosage	Frequency	Route (by mouth or injection)	Other

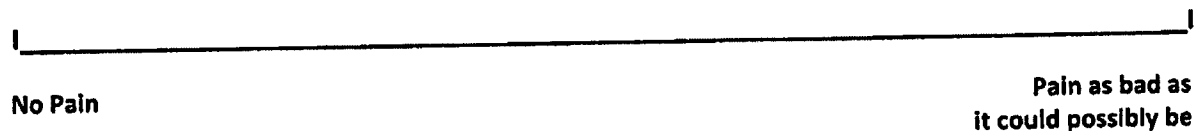
Simple Descriptive Pain Intensity Scale



0-10 Numeric Pain Intensity Scale



Visual Analog Scale (VAS)



Patients Signature: _____

Medical History

PATIENT NAME _____ DATE _____

PAST MEDICAL HISTORY - Have you had any of the following symptoms or conditions:

Allergies	YES	NO	Foot Troubles	YES	NO	Rheumatic Fever	YES	NO
Anemia	YES	NO	Gall Bladder	YES	NO	Rheumatoid Arthritis	YES	NO
Asthma	YES	NO	Pacemaker	YES	NO	Severe Headaches	YES	NO
Broken Bones	YES	NO	Head Injury	YES	NO	Shortness of Breath	YES	NO
Cancer	YES	NO	Heart Trouble	YES	NO	Yellow Jaundice	YES	NO
Diabetes	YES	NO	Hernia	YES	NO	Varicose Veins	YES	NO
Ear Trouble	YES	NO	High Blood Pressure	YES	NO	Tumor	YES	NO
Epilepsy	YES	NO	Kidney Trouble	YES	NO	Tuberculosis	YES	NO
Eye Trouble	YES	NO	Mental or Nervous	YES	NO	Skin Conditions	YES	NO
Fainting Spells	YES	NO	Disorders	YES	NO	HIV	YES	NO

Are you presently under a Doctor's care for any condition? YES NO Please Explain _____

Do you have allergies to any medication? YES NO Please Explain _____

Current Subjective Complaints

Date symptoms started : _____

Please describe your condition and how it happened: _____

What activities if any make your condition better? _____

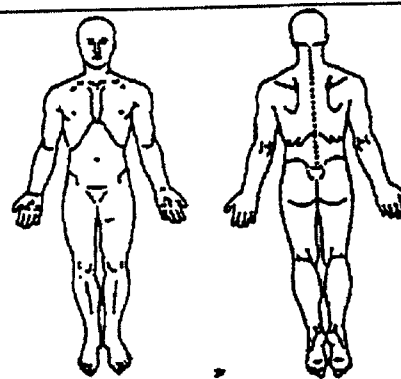
Date of last X-Rays _____ What body part were taken? _____

WOMEN ONLY ARE YOU PREGNANT? YES NO Date of last Menstrual Cycle _____

Please mark the diagram below to point out where your pain is:

HEAD

- _____ Headaches - How often? _____
- _____ Light Headed
- _____ Double Vision
- _____ Hearing Loss
- _____ Memory Loss
- _____ Ringing in Ears
- _____ Fainting
- _____ Blurred Vision
- _____ Loss of Balance
- _____ Dizziness
- _____ Sensitive to Light
- _____ TMJ / Jaw Symptoms



Action Physical Therapy LLC Financial Policy/Assignment of Benefits

Thank you for choosing Action Physical Therapy , LLC as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All copays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, Mastercard, Amex & Discover. There is a \$34 return check fee.
- If any portion of your account balance exceeds 60 days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO INDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES.

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Action Physical Therapy, LLC and any of its duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned 's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Action Physical Therapy, LLC, when which checks, drafts or money orders are made payable for services which have been rendered by Action Physical Therapy, LLC, at the request or with the knowledge and approval of the undersigned and/or the make of the check, drafts or money order. Furthermore, the undersigned allows Action Physical Therapy, LLC. Or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Action Physical Therapy, LLC. as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me The patient, to release true copies of the same to Action Physical Therapy, LLC. or any insured providing the coverage to me in connection with the process of any other claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize _____
(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Action Physical Therapy, LLC.
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Action Physical Therapy, LLC. any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Action Physical Therapy, LLC.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____

Signature of Patient (parent/guardian, if minor) _____ Date: _____

Patients Name (Please Print): _____

Insurance

We accept all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Action Physical Therapy LLC will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & represent a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Royal Palm Beach Rehab. Corp.-Financial Policy/Assignment of Benefits

Thank you for choosing Royal Palm Beach Rehab. Corp. as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All co-pays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, MasterCard, Amex & Discover. There is a \$34 return check fee.
- If any portion of your account balance exceeds 60 days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Royal Palm Beach Rehab. Corp. and any of its duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Royal Palm Beach Rehab. Corp. when which checks, drafts or money orders are made payable for services which have been rendered by Royal Palm Beach Rehab. Corp. at the request or with the knowledge and approval of the undersigned and/or the make of the check, draft or money order. Furthermore, the undersigned allows Royal Palm Beach Rehab. Corp. or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Royal Palm Beach Rehab. Corp. as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me, the patient, to release true copies of the same to Royal Palm Beach Rehab. Corp. or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize _____

(Name of Insured/Patient) _____ (Name of Insurance Carrier)

To make payable directly to: Royal Palm Beach Rehab. Corp.
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100 Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Royal Palm Beach Rehab. Corp. any right & benefits under any policy of insurance, Indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Royal Palm Beach Rehab. Corp.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____.

Signature of Patient (parent/guardian, if minor) _____ Date: _____

Patients Name (Please Print): _____

Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Royal Palm Beach Rehab. Corp. will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Physical Therapy Institute and Aquatic Rehab Inc-Financial Policy/Assignment of Benefits

Thank you for choosing Physical Therapy Institute and Aquatic Rehab Inc as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All co-pays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, MasterCard, Amex & Discover. There is a \$34 return check fee.
- If any portion of your account balance exceeds 60days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED. INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Physical Therapy Institute and Aquatic Rehab Inc and any of it's duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Physical Therapy Institute and Aquatic Rehab Inc, when which checks, drafts or money orders are made payable for services which have been rendered by Physical Therapy Institute and Aquatic Rehab Inc. at the request or with the knowledge and approval of the undersigned and/or the make of the check, draft or money order. Furthermore, the undersigned allows Physical Therapy Institute and Aquatic Rehab Inc or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Physical Therapy Institute and Aquatic Rehab Inc as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me, the patient, to release true copies of the same to Physical Therapy Institute and Aquatic Rehab Inc or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize _____

(Name of Insured/Patient) _____ (Name of Insurance Carrier)
To make payable directly to: Physical Therapy Institute and Aquatic Rehab Inc
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Physical Therapy Institute and Aquatic Rehab Inc any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Physical Therapy Institute and Aquatic Rehab Inc.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____.

Signature of Patient (parent/guardian, if minor) _____ Date: _____

Patients Name (Please Print): _____

Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Physical Therapy Institute and Aquatic Rehab Inc will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

**Royal Palm Beach Rehab. Corp., Physical Therapy Institute
and Aquatic Rehab, and Action Physical Therapy LLC.**

Royal Palm Beach

Notice of Privacy Practices

Date: _____

Patient Name: _____

This is to certify that I, _____ have been given, offered or
have seen the posted copy of the **Notice of Privacy Practices** (also known as HIPAA).

Signature of Patient/Guardian

Date

Signature of Clinic representative

Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of
Privacy Practices Form, but was unable to do so as documented below:

Date:	Initials:	Reason:
-------	-----------	---------



American Physical Therapy Association

Patient Name: _____

Date: _____

OPTIMAL INSTRUMENT Demographic Information

1. Date of Birth _____
mm / dd / yyyy
2. Sex
 - 1) Male
 - 2) Female
3. Race
 - 1) Aleut/Eskimo
 - 2) American Indian
 - 3) Asian/Pacific Islander
 - 4) Black
 - 5) White
 - 6) Other
4. Ethnicity
 - 1) Hispanic or Latino
 - 2) Not Hispanic or Latino
5. Insurance (Please check all that apply)
 - 1) Workers' compensation
 - 2) Self-pay
 - 3) HMO/PPO/private insurance
 - 4) Medicare
 - 5) Medicaid
 - 6) Auto
 - 7) Other
6. Education (Please check one)
 - 1) Less than high school
 - 2) Some high school
 - 3) High school graduate
 - 4) Attended or graduated from technical school
 - 5) Attended college, did not graduate
 - 6) College graduate
 - 7) Completed graduate school/advanced degree
7. Please check the combined annual income of everyone in your house:
 - 1) Less than \$10,000
 - 2) \$10,000-\$14,999
 - 3) \$15,000-\$24,999
 - 4) \$25,000-\$34,999
 - 5) \$35,000-\$49,999
 - 6) \$50,000-\$74,999
 - 7) \$75,000-\$99,999
 - 8) \$100,000-\$149,999
 - 9) \$150,000 or more
8. Employment/Work (Check all that apply)
 - 1) Working full-time outside of home
 - 2) Working part-time outside of home
 - 3) Working full-time from home
 - 4) Working part-time from home
 - 5) Working with modification in job because of current illness/injury
 - 6) Not working because of current illness/injury
 - 7) Homemaker
 - 8) Student
 - 9) Retired
 - 10) Unemployed
 Occupation: _____
9. Do you use a: (Check all that apply)
 - 1) Cane?
 - 2) Walker, rolling walker, or rollator?
 - 3) Manual wheelchair?
 - 4) Motorized wheelchair?
 - 5) Other: _____
10. With whom do you live? (Check all that apply)
 - 1) Alone
 - 2) Spouse/significant other
 - 3) Child/children
 - 4) Other relative(s)
 - 5) Group setting
 - 6) Personal care attendant
 - 7) Other: _____
11. Where do you live?
 - 1) Private home
 - 2) Private apartment
 - 3) Rented room
 - 4) Board and care/assisted living/group home
 - 5) Homeless (with or without shelter)
 - 6) Long-term care facility (nursing home)
 - 7) Hospice
 - 8) Other

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.

OPTIMAL INSTRUMENT

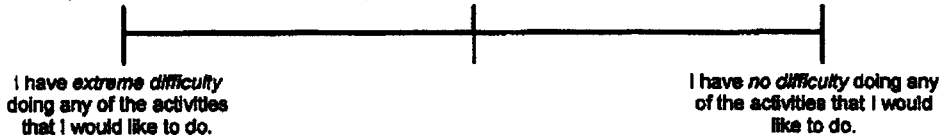
Patient Name: _____

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.



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. ____

© 2005, 2006 American Physical Therapy Association. All rights reserved. No part of this instrument may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise without prior permission of the American Physical Therapy Association. Contact permissions@apta.org or visit www.apta.org/publications.

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: _____

Date: _____

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
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 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:



© 2005, 2006 American Physical Therapy Association. All rights reserved. No part of this instrument may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise without prior permission of the American Physical Therapy Association. Contact permissions@apta.org or visit www.apta.org/publications.

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.

Scoring of OPTIMAL

The Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL) is an instrument that measures difficulty and self-confidence in performing 21 movements that a patient/client needs to accomplish in order to do various functional activities.

Scoring is relatively simple, and it can be done in three different ways. The most expedient way to calculate a total score is to sum the responses (marked on a 1 to 5 scale) across all 21 items on difficulty and on self-confidence upon both the patient's/client's admission (baseline) and discharge from physical therapy (final). Then subtract the final sum from the baseline sum. The higher the change score, the more the patient has improved. If a particular item on the OPTIMAL is marked as "Not Applicable," then this item should be dropped completely from the overall scoring. For example, suppose that one item is marked "Not Applicable." The best possible score on "Difficulty" or "Self-confidence" for this patient would be "20" (1 x 20 items) and the worst possible score would be "100" (5 x 20 items). Do not add "9" to the score ("9" is an arbitrary coding convention to distinguish the item from missing data if you are entering information into a database.)

Psychometric testing of the instrument also determined that the 21 items form three subscales: upper extremity, lower extremity; and trunk mobility. For some patients, it may be helpful to analyze changes in difficulty or self-confidence in performing specific movements by calculating a subscale score as well as a total score.

Finally, the instrument includes a question that asks the patient/client, "From the above list [referring to the 21 items], choose the 3 activities you would most like to be able to do without any difficulty," which may also provide clinically meaningful information. The therapist can calculate a specific item score to appraise the changes between admission and discharge scores on these three items. This scoring method allows the therapist to determine the outcome of treatment on the ability to perform the movements that were most important to the patient/client. This method particularly aids in the clinical decision-making process.

For more information about the psychometric properties of OPTIMAL, as well as discussing its scoring, please contact the Division of Practice and Research at the American Physical Therapy Association (APTA).

[updated 02/23/07]

Physical Therapy Institute and Aquatic Rehab

4972 Le Chalet Blvd, Suite 100
Boynton Beach, FL 33436
Ph-561-733-5590
Fax-561-740-0724

106 Ponce De Leon St
Royal Palm Beach, FL 33411
Ph-561-791-9090
Fax-561-791-9072

2632 W. Indiantown Rd.
Jupiter, Florida 33458
Ph-561-744-7373
Fax-561-743-1192

2240 Palm Beach Lakes Blvd. Suite
#125
West Palm Beach, FL 33409
Ph-561-684-8774
Fax-561-722-2564

Medicare/Medicaid Waiver Form

ATTENTION: If you have had any treatment by a Home Health Agency or if you reside in a Nursing Home, Medicare may not reimburse Physical Therapy Institute and Aquatic Rehab. for your physical therapy treatment.

Prior to receiving any out-patient physical therapy treatment from Physical Therapy Institute and Rehab. and it is your responsibility to make sure Medicare/Medicaid is aware that you have discontinued any prior Home Health services.

Please sign and date below acknowledging that you, the patient, understand that you will be billed for any and all services that are not covered by Medicare/Medicaid due to Home Health or Nursing Home treatment.

Thank You.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

Clinic Representative: JOY Fulton _____

Clinic Location: _____

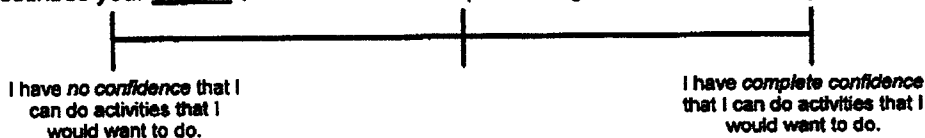
Patient Name: _____

Date: _____

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
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 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:



© 2005, 2006 American Physical Therapy Association. All rights reserved. No part of this instrument may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise without prior permission of the American Physical Therapy Association. Contact permissions@apta.org or visit www.apta.org/publications.

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.

Scoring of OPTIMAL

The Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL) is an instrument that measures difficulty and self-confidence in performing 21 movements that a patient/client needs to accomplish in order to do various functional activities.

Scoring is relatively simple, and it can be done in three different ways. The most expedient way to calculate a total score is to sum the responses (marked on a 1 to 5 scale) across all 21 items on difficulty and on self-confidence upon both the patient's/client's admission (baseline) and discharge from physical therapy (final). Then subtract the final sum from the baseline sum. The higher the change score, the more the patient has improved. If a particular item on the OPTIMAL is marked as "Not Applicable," then this item should be dropped completely from the overall scoring. For example, suppose that one item is marked "Not Applicable." The best possible score on "Difficulty" or "Self-confidence" for this patient would be "20" (1 x 20 items) and the worst possible score would be "100" (5 x 20 items). Do not add "9" to the score ("9" is an arbitrary coding convention to distinguish the item from missing data if you are entering information into a database.)

Psychometric testing of the instrument also determined that the 21 items form three subscales: upper extremity, lower extremity; and trunk mobility. For some patients, it may be helpful to analyze changes in difficulty or self-confidence in performing specific movements by calculating a subscale score as well as a total score.

Finally, the instrument includes a question that asks the patient/client, "From the above list [referring to the 21 items], choose the 3 activities you would most like to be able to do without any difficulty," which may also provide clinically meaningful information. The therapist can calculate a specific item score to appraise the changes between admission and discharge scores on these three items. This scoring method allows the therapist to determine the outcome of treatment on the ability to perform the movements that were most important to the patient/client. This method particularly aids in the clinical decision-making process.

For more information about the psychometric properties of OPTIMAL, as well as discussing its scoring, please contact the Division of Practice and Research at the American Physical Therapy Association (APTA).

[updated 02/23/07]