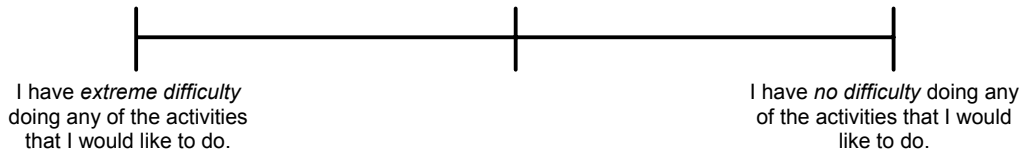


OPTIMAL INSTRUMENT

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.



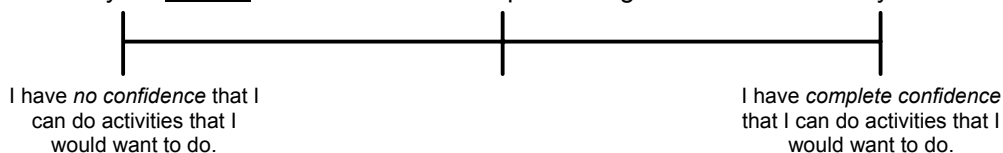
23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13)

1. ____ 2. ____ 3. ____

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:



How Did You Hear About Us?

Through our Sports Medicine & Athletic Training Program?

- Advance Rehabilitation Athletic Trainer
- Related to an athlete in our Program
- Recommended by a Coach or School Employee
- Advance advertising at a school
- Employed by a school

Through Printed Advertising?

- Magazine or Newspaper (Name of the publication: _____)
- Pamphlet
- Direct Mail
- Yellow Pages or Phone Book

- Internet or Website

- Radio Advertising

- Billboard

- Community Outreach

- Referred by a Friend

- Referred by a Family Member

- Screening Clinic

- Referred by your Doctor

- Other: _____

We would like to send you our monthly newsletter, full of information regarding your health and exciting news and events at Advance Rehabilitation! If you would like to hear from us, please provide your email address:

_____@_____

Your privacy is very important to us. Your email address is confidential and will not be given to any business outside of Advance Rehabilitation.

Advance Rehabilitation and Consulting, Inc
Conditions of Admission

Authorization for Treatment

I, the undersigned, hereby authorize and consent to rehabilitation services provided by Advance Rehabilitation and Consulting, including any procedures which may be performed during this visit for: _____

Patient Name

Assignment of Insurance Benefits and Release of Information

I hereby assign and authorize direct payment to Advance Rehabilitation and Consulting, Inc. of all insurance benefits payable to me under the terms of any insurance policy for the services rendered, but not to exceed the regular charge for services received.

I authorize any holder of medical information about me or any information needed to determine benefits payable for related services to be released to my insurance carrier, third party payor, and managed care organization or to any other insurance carrier, including worker's compensation claims. I authorize a copy of the authorization to be used in place of the original.

Medicare Patient Certification

I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

Medicaid Authorization and Assignment

I request that payment of authorized Medicaid, Medigap or other Medical Assistance programs be made on my behalf to the above provider for services furnished to me by the provider/supplier. I authorize any holder of medical information about me or any information needed to determine benefits payable to be released to my insurance carrier. My signature certifies that I have received a service beginning with the date below. I understand that payment for this service will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State Law.

Personal Valuables/Dependents/Visitors

It is understood and agreed that Advance Rehabilitation and Consulting, Inc. is not responsible for loss or damage to any personal valuables or properties. In order to maximize safety, small children will not be allowed in the treatment area of the clinic. If older children are present, please keep them off the exercise equipment in order to prevent injuries. There may be exceptions, please ask if you have any concerns or questions. We will do everything possible to accommodate your schedule if you are a caretaker of small children.

Financial Agreement, Guarantee of Account

I, the undersigned agree whether I sign as parent, guardian, spouse, agent, guarantor or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of Advance Rehabilitation and Consulting in accordance with the regular rates and terms of the Facility. I understand that therapy services are rendered and charged to the patient and not to the insurance company, and the facility cannot accept total responsibility for collection of claims nor for negotiating a disputed settlement. I agree to be responsible for all deductibles, coinsurance and non-covered portions of services performed. I understand that Advance Rehabilitation and Consulting, Inc. is not a party to any lawsuit I may have due to litigation. I further understand that although information will be provided to my attorney, I am fully responsible to the provider for payment in full under the regular terms of the practice. Should the account be referred to an agency or attorney for collection, I shall pay actual attorney's fees and collection expense.

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As indicated in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing below, you are stating that you have reviewed the Notice of Privacy Practices. Our Notice of Privacy Practices is posted in the waiting area, but you may request a written copy of the Notice at any time. You may also ask any questions about the Notice at any time.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS

Signature of Patient or Responsible Party

Relationship to Patient

Date

Witness

Date

Advance Rehabilitation and Consulting, Inc

Patient Authorization for Use and/or Disclosure of Protected Health Information

| | |
|-------------------------|----------------|
| Patient Name: | |
| Social Security Number: | Date of Birth: |

I hereby authorize Advance Rehabilitation and Consulting, Inc. to use and/or obtain my health information without my consent for the purposes of treatment, payment or other healthcare operations.

I also hereby authorize Advance Rehabilitation and Consulting, Inc. to use and/or disclose any of my health information related to my current diagnosis, illness and/or injury to individuals and/or groups of individuals listed below (such as family, members of my household, close personal friends or anyone else) by my request so that all my rehabilitation needs can be met. The health information that I authorize to be used and/or disclosed is that information acquired during my care with Advance Rehabilitation and Consulting, Inc. and any health information that pertains to my care including past medical history and previous dates of service and those services received up to my discharge from Advance Rehabilitation and Consulting, Inc.

Names of Individuals and/or Groups of Individuals I authorize Advance Rehabilitation and Consulting, Inc. to disclose my health information to:

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying Advance Rehabilitation and Consulting, Inc. in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
4. I understand that I will receive a copy of this Authorization form after I sign it.
5. I understand that the Notice of Privacy Practices is posted in the clinic for my review. I also understand that a copy of the Notice is available to me, at my request.
6. I understand that this Authorization will expire on ___/___/___ (DD/MM/YR) or upon the following event (*if for research put "None" or "End of the research study"*): _____.

Signature of Patient or Patient's Representative

Date

Printed Name of Patient's Representative (*if applicable*)

Representative's Relationship to Patient (*if applicable*)

PATIENT MEDICAL HISTORY

Answers to the following questions will assist the therapist in providing a safe and effective treatment program.

Patient Name: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

Problems to be treated:

Have you had treatment for this problem before? YES NO

If yes, state where: _____ Approximately When: _____

Treatment given:

Have you had surgery associated with this problem? YES NO

If YES, please list the approximate date and type of surgery:

List any other major illness or surgery that has occurred in the past year:

Please list any current medications you are taking:

Please list any allergies (latex, drug etc...) and describe any drug reactions:

Please circle any of the following you may have/wear:

Dentures Pacemaker Metal/Foreign Object Implants

Are you pregnant? YES NO

Please circle all that apply:

| | | |
|--------------------------|---------------------|-------------------------|
| AIDS | Drug Abuse | Motor Vehicle Accident |
| Allergies | Emphysema | Psychiatric Treatment |
| Anemia | Fainting | Rheumatic Heart Disease |
| Arthritis | Fractures | Seizures |
| Asthma | Glaucoma | Shortness of Breath |
| Back Trouble | Heart Disease | Sinusitis |
| Bleeding Disease | Heart Attack | Stomach Ulcers |
| Bronchitis | Heart Murmur | Stroke |
| Cancer | Hepatitis | Swelling of Hands/Feet |
| Chest Pain | Herpes | Thyroid Disease |
| Congenital Heart Defect | High Blood Pressure | Tuberculosis |
| Congestive Heart Failure | Jaundice | Rheumatic Fever |
| Convulsions | Kidney Disease | |
| Diabetes | Liver Disease | |

Have you ever had Physical/Occupational Therapy before? YES NO

If YES, please list reasons for therapy and when:

What do you expect to gain/accomplish in receiving therapy? _____

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS CORRECT

Patient Name

Date

ADVANCE REHABILITATION PATIENT INFORMATION

| | | | |
|---|--|---|--|
| TODAY'S DATE ____/____/____ | ARE YOU CURRENTLY RECEIVING HOME HEALTH? | YES | NO |
| | HAVE YOU RECEIVED HOME HEALTH WITHIN THE PAST 30 DAYS? | YES | NO |
| PATIENT INFORMATION | | | |
| NAME (LAST) | | (FIRST) | |
| | | (MI) | |
| ADDRESS | | CITY | STATE |
| | | | ZIP |
| TELEPHONE (____)____-____ | DATE OF BIRTH ____/____/____ | SS # ____-____-____ | SEX M F |
| | | MARITAL STATUS MARRIED WIDOWED SINGLE DIVORCED | |
| EMAIL ADDRESS (OPTIONAL) <small>THIS INFORMATION IS FOR ARCI ONLY – WILL NOT BE SHARED WITH OUTSIDE SOURCES</small> | | CELL PHONE | |
| PATIENT EMPLOYER | | OCCUPATION | EMPLOYER TELEPHONE (____)____-____ |
| ADDRESS | | CITY | STATE |
| | | | ZIP |
| SPOUSE INFORMATION | | | |
| SPOUSE NAME (LAST) | | (FIRST) | |
| | | (MI) | |
| SPOUSE EMPLOYER | | OCCUPATION | SPOUSE DOB ____/____/____ |
| CONTACT INFORMATION | | | |
| EMERGENCY CONTACT | (OTHER THAN HOME PHONE) | TELEPHONE (____)____-____ | RELATIONSHIP |
| CONTACT PERSON (HIPAA) | | TELEPHONE (____)____-____ | RELATIONSHIP |
| ACCIDENT INFORMATION | | | |
| DATE OF ACCIDENT /INJURY ____/____/____ | AUTO OR WORK RELATED YES NO STATE WHERE ACCIDENT OCCURRED _____ | SPORTS RELATED YES NO | SCHOOL _____ |
| INSURANCE INFORMATION | | | |
| 1 PRIMARY INSURANCE CARRIER | | | |
| PATIENT RELATIONSHIP TO POLICY HOLDER | | SELF | SPOUSE |
| | | DEPENDENT | OTHER _____ |
| 2. SECONDARY INSURANCE CARRIER | | | |
| PATIENT RELATIONSHIP TO POLICY HOLDER | | SELF | SPOUSE |
| | | DEPENDENT | OTHER _____ |
| 3. TERTIARY INSURANCE CARRIER | | | |
| PATIENT RELATIONSHIP TO POLICY HOLDER | | SELF | SPOUSE |
| | | DEPENDENT | OTHER _____ |
| GUARANTOR/ RESPONSIBLE PARTY (Required if patient is 18 years or under) | | | |
| NAME | | RELATIONSHIP | |
| | | | |
| ADDRESS | | CITY | STATE |
| | | | ZIP |
| TELEPHONE | HOME (____)____-____ | OTHER (____)____-____ | |
| EMAIL _____ | | | |