

PATIENT NAME: _____
DATE OF BIRTH: ____/____/____

IDEAL HEALTH AND REHAB, P.L.
DR. MEHRTASH DAVARI
8430 W. BROWARD BLVD., STE. 250
PLANTATION, FL 33324
(954) 772-9052
FAX: (954) 628-5109

PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: ____/____/____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____ AGE: ____ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-____ YES No

WORK PHONE #: (____) ____-____ YES No

CELL PHONE #: (____) ____-____ YES No

E-MAIL: _____ YES No

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES No

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR CLINICAL INFORMATION?
____ YES NAME(S) _____

____ No

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-____

INSURANCE INFORMATION

ARE YOU ELIGIBLE FOR MEDICARE AND/OR MEDICAID? _____

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT - HOW LONG AGO? _____ ☐ SMOKE _____ PACKS/DAY FOR _____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT - HOW LONG AGO? _____ TYPE _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN-AGE(S) _____ ☐ PET(S)-WHAT KIND? _____

☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

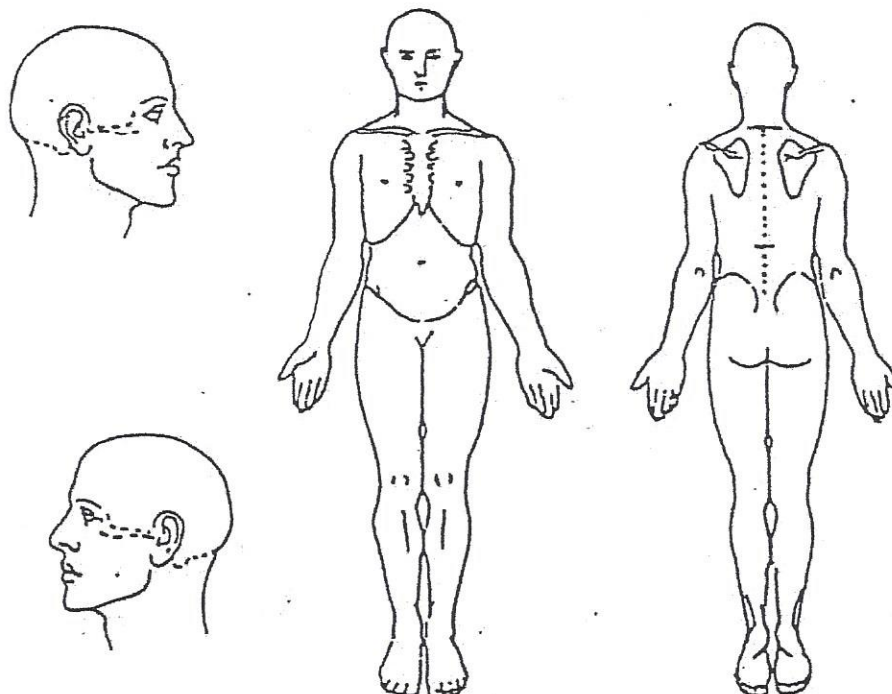
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HAVE YOU HAD THIS CONDITION IN THE PAST? _____ IF YES, WHEN? _____

DID YOU SEEK TREATMENT BY A DOCTOR FOR THIS CONDITION? _____ IF YES, BY WHOM? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ No

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ No

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE

Informed Consent for Chiropractic Treatment

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- | | |
|---|---|
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> increased symptoms and pain |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> No improvement of symptoms or pain |
| <input type="checkbox"/> Sprains/strains | <input type="checkbox"/> Infection (acupuncture) |
| <input type="checkbox"/> Burns or frostbite (physical therapy) | <input type="checkbox"/> Punctured lung (acupuncture) |
| <input type="checkbox"/> Worsening/aggravation of spinal conditions | <input type="checkbox"/> Other _____ |

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: _____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

print name

signature of patient

date signed

To be completed by the patient's representative:

print name of patient

print name of patient's representative

signature of patient's representative

as: _____
relationship/authority of patient's representative

date signed

To be completed by doctor or staff:

witness to patient's signature

translated by

Revised May 2013

date

date

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

_____ Patient initials to indicate copy received.

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VERIFICATION OF NON-PREGNANCY

Date: _____

Name: _____ DATE OF BIRTH _____

Address: _____

Telephone: _____

By my signature on this form, I, _____, do hereby state that, to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this particular time.

Patient's Signature: _____

Witness: _____

Witness: _____

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TREATMENT (MODALITIES) ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Explanation of Treatments (Modalities) form and I have been provided an opportunity to review it.

Name _____

Signature _____

Date _____

Witness _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on **March 22, 2004** and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, private practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the Right to:

1. Change our privacy practices and the terms of the notice at anytime, provide that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an appointment change in our policy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclose will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

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NOTICE OF PRIVACY PRACTICES

Additional Uses And Disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following information about you will be placed in our facilities directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to the public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

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Explanation of Treatments

Each modality in this office is timed for at least 15 minutes excluding ultrasound which is 8-15 minutes according to PT rules and the AMA Guidelines 5th Edition, the current edition. On the SOAP note it is stated what modalities are being applied.

97010 Hot Pack / Cold Pack

Cold: Cold is being used as a local, superficial hypothermal effect on the body. It tends to cool body tissue thereby decreasing tissue metabolism. A vasoconstriction occurs and there is reduced nerve conduction and analgesia. Pain and swelling reduction is the desired effect.

Heat: Heat is being used as a local, superficial hyper-thermal effect on the body. It tends to increase the temperature in the body, thereby causing a vasodilatation. There is an analgesic effect along with an increase in the local circulation. As a result of the calming effect, the tissue relaxes and muscular spasm is reduced.

97012 Mechanical Traction

Mechanical traction is being applied to separate and stretch the spinal segments. It is also being applied to promote distraction and gliding of the joint facet. It is also used to dissipate edema as a result of the movement involved in this modality. The alternating pull and relaxation helps to promote joint hydration.

97014 Electrical Muscle Stimulation (Unattended)

Low Volt Electrical Muscle Stimulation: LVMS is used to help reduce edema, adhesions, and muscle spasm. It also has a positive effect on pain and provides passive exercise and relaxes the tissue.

High Volt Electrical Muscle Stimulation: HVMS is used to help reduce pain and muscle spasm. It also helps to reduce inflammation and promote tissue healing and repair.

Low Frequency Therapy: Low Frequency Therapy is used to help reduce post traumatic inflammation, reduce swelling, and promotes wound healing.

97035 Ultrasound

Ultrasound is used to provide a deep penetrating heat effect within the tissue. It also introduces a micro massage within the tissue by breaking down scar tissue and reducing edema. This modality also produces a mild sedative effect. Overall, ultrasound provides heat and micro massage where muscles, tendons, and ligaments attach to bone.

97139 Cold Laser Therapy (attended)

Cold Laser Therapy is a wand-like device that introduces a laser beam up to 5 cm into the body. It produces a therapeutic response, reducing edema, increasing blood flow, reducing pain, reduces muscle spasms, and increasing the healing process.

97124 Massage Therapy

Massage is defined as the act or art of treating the body by rubbing, kneading, pressure or friction, patting, or the like, to stimulate circulation, increase suppleness, relieve tension, reduce muscle spasms, and reduce edematous tissue.

97140 Manual Therapy

Manual therapy is a collection of techniques in which hand movements are skillfully applied to mobilize joints and soft tissues. These techniques may be used to alleviate pain, improve extension and motion, induce relaxation, reduce edema, and improve pulmonary and musculoskeletal function.

97110 Therapeutic Exercises

Therapeutic exercise is a therapy intervention encompassing a broad range of activities designed to restore or improve musculoskeletal, cardiopulmonary and/or neurological function. Some form of therapeutic exercise is indicated in almost every case. Physicians/Therapists may assist clients in designing therapeutic exercise programs to prevent injury or secondary impairments. In addition, physicians/therapists use therapeutic exercise as one component of patient care to improve functional ability and general well-being in those who are experiencing limitations or disability due to a disease, disorder, trauma, or surgery.