PATIENT HISTORY INFORMATION

Date ____________________

PATIENT ______________________________ **Birthdate** ______________ Age ______

(FULL NAME, PLEASE DO NOT USE INITIALS)

Married ☐ Single ☐ Widowed ☐ Male ☐ Female ☐ **Soc. Sec. #** ____________________

Home Address ____

City ______________ State ____ Zip Code ______ Home Phone ________ Cell ________

Patient Employed by ______________________________ Occupation ______________

Business Address ____

City ______________ State ______ Zip Code ________ Business Phone ____________

Name of Spouse ____________________ **Soc. Sec. #** ____________ **DOB** ________

Spouse Employed by ______________________________ Business Phone ____________

PATIENT REFERRED by ____

IF PATIENT IS INSURED THROUGH A PARENT, COMPLETE THIS SECTION

FATHER: Name ____________________ **Soc. Sec. #** ____________ **DOB** ________

Employer ______________________________ Employer Phone ______________

MOTHER: Name ____________________ **Soc. Sec. #** ____________ **DOB** ________

Employer ______________________________ Employer Phone ______________

HOME ADDRESS OF PARENT(S) if different than patient's ______________________________

____ Phone ______________

INSURANCE INFORMATION

Company Name ______________________________ I.D. # ______________

Address ____

Secondary Insurance ______________________________ I.D. # ______________

Address ____

If this insurance is secondary to Medicare, please indicate whether it is a purchased supplement ____ or is provided through employment ____; also list the name of the policyholder ______________________________

Job Related Injury (Worker's Compensation): Yes ☐ No ☐ Contact person ______________

Worker's Compensation Claim Number ______________ Phone ______________

Address ____

If you are being represented by an Attorney, please give name and address:

Name ______________________________ Phone ______________

Address ____

ROCK VALLEY
PHYSICAL THERAPY
Making Better Lives.

PATIENT HISTORY QUESTIONNAIRE

Name ______________________________ Today's Date ______________

Age _____ Date of Birth ____________ Height _______ Weight _______ Date of Next Dr. Appt. ____________

Occupation ______________________ Leisure Activities ______________________

Family Physician ______________________ Referring Physician ______________________

What is your chief complaint? ____

What caused your symptoms to begin? ____

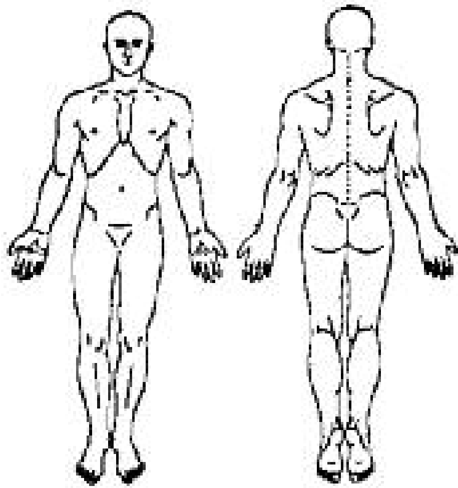
____ Date symptoms began ______________

Please describe your symptoms (i.e. sharp, dull, tingling, etc.) ______________________

____

Indicate on the diagrams below, the area(s) or location(s) where you are currently experiencing symptoms, using the following key:

PPPPP = pins & needles SSSSS = stabbing
XXXXX = burning ZZZZZ = deep ache



Please indicate below the intensity of your symptoms. (Circle the appropriate number.)

(0 = no symptoms, 10 = worst possible symptoms)

Current:

0 1 2 3 4 5 6 7 8 9 10

Best:

0 1 2 3 4 5 6 7 8 9 10

Worst:

0 1 2 3 4 5 6 7 8 9 10

Average:

0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms? (Please check one.)

_____ Constantly (24 hrs/day) _____ Occasionally (8-16 hrs/day)
_____ Frequently (16-23 hrs/day) _____ Intermittently (0-8 hrs/day)

Please list any other treatments you have received for this condition. ______________________

____

____

Has any special testing been done for this condition, such as x-ray or MRI? If so, please describe.

____

____

Please check if you, or a member of your family, have or has ever had any of the following:

You	Family		You	Family		You	Family	
_____	_____	Heart problems	_____	_____	Radiculitis	_____	_____	Cancer
_____	_____	High blood pressure	_____	_____	Sciatica	_____	_____	Thyroid problems
_____	_____	Circulatory problems	_____	_____	Deep vein thrombosis	_____	_____	Seizures
_____	_____	Asthma	_____	_____	Raynaud's	_____	_____	Multiple Sclerosis
_____	_____	Emphysema/bronchitis	_____	_____	Vertigo	_____	_____	Hepatitis
_____	_____	COPD	_____	_____	Dementia	_____	_____	Tuberculosis
_____	_____	Rheumatoid Arthritis	_____	_____	Depression	_____	_____	Stroke
_____	_____	Other arthritic conditions	_____	_____	Obesity	_____	_____	Kidney disease
_____	_____	Diabetes	_____	_____	Difficulty walking due to a joint disorder	_____	_____	Anemia
_____	_____	Chronic ulcer				_____	_____	Chemical dependency
_____	_____	Osteoporosis	_____	_____	Other ____________________			

Please list any surgeries or other conditions you have experienced that required hospitalization, including the approximate date. ____

____

____

Please list any medications you are currently taking (prescription and over-the-counter).

____

____

____

How many caffeinated beverages do you drink per week? ____________________

Do you use nicotine products? YES NO How much per day? ____________________

Do you drink alcohol YES NO # of days per week _____ # of drinks in average sitting _____

Are you currently receiving any type of home health services? YES NO

If yes, please provide the name of the agency. ____________________

Are you here due to a problem with your low back? YES NO If YES, skip to the next page.

Have you recently noted any of the following? (Please check all that apply.)

_____ weight loss/gain
_____ nausea/vomiting
_____ dizziness/lightheadedness
_____ fatigue
_____ blurred vision
_____ blackouts
_____ difficulty swallowing
_____ difficulty sleeping
_____ weakness
_____ fever/chills/sweats
_____ numbness or tingling
_____ balance disturbances
_____ hearing disturbances
_____ difficulty with communication
_____ unintentionally dropping objects

Thank you for taking the time to complete this questionnaire.

The mission of Rock Valley Physical Therapy is to meet the needs of our community by providing skilled, highly-effective physical rehabilitation services and by fostering a timely, optimal outcome for our patients.

Compliance with your scheduled appointment time is mandatory. You are scheduled for a block time, and to be late or to miss with little notice does not allow us to fill your space. **We reserve the right to charge for a missed appointment if not cancelled at least 24 hours prior to your scheduled time.**

Another responsibility of the patient is for his/her charges for care. When delivering physical therapy or occupational therapy treatment, we are entering into an agreement with you, not with a third-party insurance company or an attorney, if in litigation. We will bill your insurance for you, but if our charges are not covered or paid in full by them, the balance becomes due and payable by you, the patient/responsible party, within 30 days of the insurance payment and/or denial, unless other arrangements have been made with the Billing Office. If the bill has not been paid within the 30 days, we reserve the right to discontinue treatment.

Medicare may not approve certain supplies. If your therapist recommends and/or gives you a supply item to take home, you must check with our front office staff regarding coverage BEFORE ACCEPTING THE ITEM.

Rock Valley Physical Therapy does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact the Administrative Assistant – (309) 743-2070, TDD/Relay Iowa.

Rock Valley Physical Therapy is not responsible for determining insurance coverage for services. Please contact your insurance company directly if you have any questions regarding coverage.

This is to verify that I have read and agree with the above.

_______________________________ Patient or responsible party

_______________________________ Date

PATIENT'S or AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment, or assign insurance payments directly to Rock Valley Physical Therapy.

I authorize you to speak to _______________________________ regarding my account/treatment.
name(s) of family member / friend

_______________________________ Patient or responsible party

_______________________________ Date

I, _______________________________, have received the **NOTICE OF PRIVACY PRACTICES** from Rock Valley Physical Therapy.

_______________________________ Patient or responsible party

_______________________________ Date

As a staff member of Rock Valley Physical Therapy, I, _______________________________, state that _______________________________ has been given our Notice of Privacy Practices, though he/she declined to sign this acknowledgement.

_______________________________ Staff Member

_______________________________ Date

SUPPLIER STANDARDS

1. A supplier will fill orders from its own inventory or inventory of other companies with which it has contracts to fill such orders; or fabricates or fits items for sale from supplies it buys under a contract.
2. A supplier is responsible to oversee delivery of items that the supplier ordered for the beneficiary. The supplier is also responsible to assure delivery of large items to the beneficiary.
3. A supplier honors all warranties, express or implied, under applicable State law.
4. A supplier will answer questions or complaints a beneficiary has about an item or use of an item that is sold or rented to the beneficiary. If the beneficiary has questions about Medicare, the supplier will refer the beneficiary to the appropriate carrier.
5. A supplier maintains and repairs directly, or through a service contract with another Company, items it rents to a beneficiary.
6. A supplier accepts returns of substandard (less than full quality for a particular item) or unsuitable items (inapropriate for the beneficiary at the time it was fitted and/or sold) from the beneficiary.
7. A supplier discloses consumer information to each Medicare customer. This consists of a copy of these supplier standards to which it must conform.
8. A supplier complies with the disclosure provisions in Title XI of the of the Social Security Act, section 1124A(a).

NOTE:

If you do not know which Regional Carrier to call, please ask the supplier where your claims are billed.

MEDIGAP (Medicare Supplement) STATEMENT:

I request that payment of authorized MediGap benefits be made either to me or on my behalf to Rock Valley Physical Therapy for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to ______________________________

any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Name ______________________ MediGap Policy Number ______________________

Beneficiary Signature ______________________ Date ______________________

Dizziness Handicap Inventory

Name: _______________________________ DOB: __________________ Date: ____________

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer “yes”, “no” or “sometimes” to each question.
Answer each question as it applies to your dizziness or unsteadiness only.

ITEM	QUESTION		Y	N	S
1	Does looking up increase your problem?	P			
2	Because of your problem, do you feel frustrated?	E			
3	Because of your problem, do you restrict your travel for business or recreation?	F			
4	Does walking down the aisle of a supermarket increase your problem?	P			
5	Because of your problem, do you have difficulty getting into or out of bed?	F			
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or to parties?	F			
7	Because of your problem, do you have difficulty reading?	F			
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P			
9	Because of your problem, are your afraid to leave your home without having someone accompany you?	E			
10	Because of your problem, are you embarrassed in front of others?	E			
11	Do quick movements of your head increase your problem?	P			
12	Because of your problem, do you avoid heights?	F			
13	Does turning over in bed increase your problem?	P			
14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	F			
15	Because of your problem, are you afraid people may think you are intoxicated?	E			
16	Because of your problem, is it difficult for you to walk by yourself?	F			
17	Does walking down a sidewalk increase your problem?	P			
18	Because of your problem, is it difficult for you to concentrate?	E			
19	Because of your problem, is it difficult for you to walk around the house in the dark?	F			
20	Because of your problem, are you afraid to stay at home alone?	E			
21	Because of your problem, do you feel handicapped?	E			
22	Has your problem placed stress on your relationship with members of your family or friends?	E			
23	Because of your problem, are you depressed?	E			
24	Does your problem interfere with your job or household responsibilities?	F			
25	Does bending over increase your problem?	P			
			X 4	X 0	X 2
		=			
		TOTAL			

P ________________ E ________________ F ________________

100-70= severe perception of having a handicap, 69-40= moderate perception of handicap, 39-0= low perception of handicap