



## 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 \_\_\_\_\_



## 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? \_\_\_\_\_

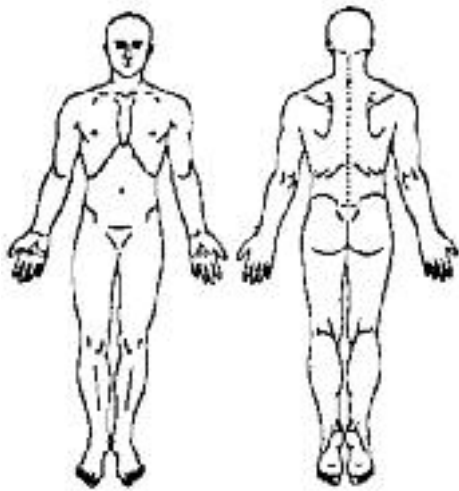
What caused your symptoms to begin? \_\_\_\_\_

\_\_\_\_\_ 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	_____	_____	Anemia
_____	_____	Chronic ulcer	_____	_____	due to a joint disorder	_____	_____	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	_____ weakness
_____ nausea/vomiting	_____ fever/chills/sweats
_____ dizziness/lightheadedness	_____ numbness or tingling
_____ fatigue	_____ balance disturbances
_____ blurred vision	_____ hearing disturbances
_____ blackouts	_____ difficulty with communication
_____ difficulty swallowing	_____ unintentionally dropping objects
_____ difficulty sleeping	

*Thank you for taking the time to complete this questionnaire.*



**ROCK VALLEY**  
 PHYSICAL THERAPY  
*Making Better Lives.*

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 (inappropriate 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 \_\_\_\_\_



**ROCK VALLEY**

PHYSICAL THERAPY

*Making Better Lives.*

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Do you usually experience *pressure* in the lower abdomen?

\_\_\_ NO                      \_\_\_ YES

**If yes, how much does this bother you?**

\_\_\_ 1 – Not at all      \_\_\_ 2 – Somewhat      \_\_\_ 3 – Moderately      \_\_\_ 4 – Quite a bit

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2. Do you usually experience *heaviness or dullness* in the pelvic area?

\_\_\_ NO                      \_\_\_ YES

**If yes, how much does this bother you?**

\_\_\_ 1 – Not at all      \_\_\_ 2 – Somewhat      \_\_\_ 3 – Moderately      \_\_\_ 4 – Quite a bit

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3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?

\_\_\_ NO                      \_\_\_ YES

**If yes, how much does this bother you?**

\_\_\_ 1 – Not at all      \_\_\_ 2 – Somewhat      \_\_\_ 3 – Moderately      \_\_\_ 4 – Quite a bit

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4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?

\_\_\_ NO                      \_\_\_ YES

**If yes, how much does this bother you?**

\_\_\_ 1 – Not at all      \_\_\_ 2 – Somewhat      \_\_\_ 3 – Moderately      \_\_\_ 4 – Quite a bit

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5. Do you usually experience a feeling of incomplete bladder emptying?

\_\_\_ NO                      \_\_\_ YES

**If yes, how much does this bother you?**

\_\_\_ 1 – Not at all      \_\_\_ 2 – Somewhat      \_\_\_ 3 – Moderately      \_\_\_ 4 – Quite a bit

6. Do you ever have to push up on a bulge in the vaginal area with your finger to start or complete urination?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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7. Do you feel you need to strain too hard to have a bowel movement?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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8. Do you feel you have not completely emptied your bowels at the end of the bowel movement?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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9. do you usually lose stool beyond your control if your stool is well formed?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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10. Do you usually loose stool beyond your control if your stool is loose or liquid?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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11. Do you usually lose gas from the rectum beyond your control?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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12. Do you usually have pain when you pass your stool?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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15. Do you usually experience frequent urination?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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16. Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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17. Do you usually experience urine leakage related to coughing, sneezing, or laughing?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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18. Do you usually experience small amounts of urine leakage (that is, drops)?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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19. Do you usually experience difficulty emptying your bladder?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

---

20. Do you usually experience *pain or discomfort* in the lower abdomen or genital region?

NO  YES

**If yes, how much does this bother you?**

1 – Not at all  2 – Somewhat  3 – Moderately  4 – Quite a bit

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**Thank you for taking the time to complete this questionnaire**

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## KEEPING A RECORD OF BLADDER FUNCTION

**Please complete a bladder log every day for 2 days and bring it to your appointment.**

**Please do at least one day on working day.**

The main purpose of a bladder log is to document how your bladder functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns. At first, the log is used as an evaluation tool. Later, it will be used to measure your progress on bladder retraining or leakage episodes.

Your log will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of day exactly what happened in the morning.

### INSTRUCTIONS

#### **Column 1 – Time of Day**

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold. Select the hour block that corresponds with the time of day you are recording information.

#### **Column 2 – Type & Amount of Fluid & Food Intake**

- Record the type and amount of **fluid** you drank
- Record the type and amount of **food** you ate
- Record when you woke up for the day and the hour you went to sleep

#### **Column 3 – Amount Voided (Urinated): Two methods**

Record the time of day and the amount voided. Use the first method unless directed by your health care provider to directly measure or count urine amounts. Record a bowel movement with a BM at the appropriate time.

1. Place a S, M, L, in the box at the corresponding time interval each time you urinate.  
**S- SMALL**= seemed like a small amount, or urinated “just in case”.  
**M- MEDIUM** = seemed like an 8 ounce measuring cup would run over.  
**L- LARGE** = seemed like the amount you urinate when you first wake up in the morning.
2. If you have difficulty gauging the amount of urine, you may record the seconds by counting “one-one thousand” (this equals one second) while emptying your bladder. Record the number of seconds it took you to void.

#### **Column 4 – Amount of Leakage**

Record the amount of urine loss at the time it occurred.

**S- SMALL**= drop or two of urine

**M- MEDIUM** = wet underwear

**L- LARGE** = wet outerwear or floor

#### **Column 5 – Was Urge Present**

Describe the urge sensation you had as:

**1- MILD** = first sensation of need to go

**2- MODERATE** = stronger sensation or need

**3- STRONG** = need to get to a toilet, move aside!

**Column 6 – Activity with Leakage** Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, bent over, lifted something or had strong urge.

**Comments** – (at the bottom of the log table) Special problems and new or changes in medication are recorded here. If a pad change was needed during the day at the bottom of the page.



**Daily Voiding Log Sample**

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided in Ounces or S /M /L or seconds	Amount of Leakage S /M /L	Was Urge Present 1/ 2/ 3	Activity with Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am	Woke up at 6:45 am	L		3	
7:00 am	Coffee, bagel				
8:00 am			M		Fast walking
9:00 am	Apple	M		2	
10:00 am					
11:00 am		S		1	Key in the door
<b>NOON</b>	Tuna sandwich, milk, pear				
<b>1:00 pm</b>					
<b>2:00 pm</b>		M		2	
<b>3:00 pm</b>	Tea, cookies		S		Running water
<b>4:00 pm</b>					
<b>5:00 pm</b>					
<b>6:00 pm</b>	Chicken, corn pudding, salad, apple juice	M		3	
<b>7:00 pm</b>					
<b>8:00 pm</b>			S	3	
<b>9:00 pm</b>					
<b>10:00 pm</b>	To bed at 10:30	M		3	
<b>11:00 pm</b>					

Comments: week before period Number of pads: 2

## DAILY VOIDING LOG

Name \_\_\_\_\_

Date \_\_\_\_\_

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided Ounces, S/ M/ L or Seconds	Amount of Leakage S/ M/ L	Was Urge Present 1/ 2/ 3	Activity with Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
<b>NOON</b>					
<b>1:00 pm</b>					
<b>2:00 pm</b>					
<b>3:00 pm</b>					
<b>4:00 pm</b>					
<b>5:00 pm</b>					
<b>6:00 pm</b>					
<b>7:00 pm</b>					
<b>8:00 pm</b>					
<b>9:00 pm</b>					
<b>10:00 pm</b>					
<b>11:00 pm</b>					

Comments \_\_\_\_\_

Number of pads used today \_\_\_\_\_