Please complete opposite side

FUNCTIONAL INDEX

Choose the one answer in each section that best describes your condition.

WALKING
- Symptoms do not prevent me walking any distance.
- Symptoms prevent me walking more than 1 mile.
- Symptoms prevent me walking more than 1/4 mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

WORK
(Appplies to work in home and outside)
- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all (only light duty).
- I cannot do any work at all.

PERSONAL CARE
(Washing, Dressing, etc.)
- I can manage all personal care without symptoms.
- I can manage all personal care with some increased symptoms.
- Personal care requires slow, concise movements due to increased symptoms.
- I need help to manage some personal care.
- I need help to manage all personal care.
- I cannot manage any personal care.

SLEEPING
- I have no trouble sleeping.
- My sleep is mildly disturbed (less than 1 hr. sleepless).
- My sleep is moderately disturbed (1–2 hrs. sleepless).
- My sleep is greatly disturbed (3–5 hrs. sleepless).
- My sleep is completely disturbed (5–7 hrs. sleepless).

RECREATION/SPORTS
(Indicate Sport if Appropriate ________________________)
- I am able to engage in all my recreational/sports activities without increased symptoms.
- I am able to engage in all my recreational/sports activities with some increased symptoms.
- I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
- I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
- I can hardly do any recreational/sports activities because of increased symptoms.
- I cannot do any recreational/sports activities at all.

STAIRS
- I can walk stairs comfortably without a rail.
- I can walk stairs comfortably, but with a crutch, cane, or rail.
- I can walk more than 1 flight of stairs, but with increased symptoms.
- I can walk less than 1 flight of stairs.
- I can manage only a single step or curb.
- I am unable to manage even a step or curb.

UNEVEN GROUND
- I can walk normally on uneven ground without loss of balance or use of a cane or crutches.
- I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
- I have to walk very carefully on uneven ground without using a cane or crutches.
- I have to walk very carefully on uneven ground even when using a cane or crutches.
- I have to walk very carefully on uneven ground and require physical assistance to manage it.
- I am unable to walk on uneven ground.

STANDING
- I can stand as long as I want without increased symptoms.
- I can stand as long as I want, but it gives me extra symptoms.
- Symptoms prevent me from standing for more than 1 hour.
- Symptoms prevent me from standing for more than 30 minutes.
- Symptoms prevent me from standing for more than 10 minutes.
- Symptoms prevent me from standing at all.

SQUATTING
- I can squat fully without the use of my arms for support.
- I can squat fully, but with symptoms or with use of my arms for support.
- I can squat 3/4 of my normal depth, but less than fully.
- I can squat 1/2 of my normal depth, but less than 3/4.
- I can squat 1/4 of my normal depth, but less than 1/2.
- I am unable to squat any distance due to symptoms .

SITTING
- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- My symptoms prevent me sitting more than 1 hour.
- My symptoms prevent me sitting more than 1/2 hour.
- My symptoms prevent me sitting more than 10 minutes.
- My symptoms prevent me from sitting at all.

* Lumbar questions adapted from Oswestry.

ACUITY (Answer on initial visit.)

How many days ago did onset/injury occur? __________ days

Please complete opposite side

© 2010 Therapeutic Associates, Inc. (Revised: 10/20/10) FORM C004LE Lower Extremity
PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE
With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)

-7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Very Much Worse Unchanged Completely Recovered

WORK STATUS (check most appropriate)
1. □ No lost work time
2. □ Return to work without restriction
3. □ Return to work with modification
4. □ Have not returned to work
5. □ Not employed outside the home

Work days lost due to condition: ____________ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: ____________

PAIN INDEX
Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain ____________________________ Worst Pain Imaginable
PATIENT HISTORY QUESTIONNAIRE - PT

Date _____________________

Name _____________________ DOB _______ Age _______ Height _______ Weight _______

Date of Next Visit with Referring Doctor _________________ Family Doctor ____________________

Employer/Occupation _____________________ Leisure Activities _____________________

Describe the reason you are here __________________________________________________________

Date Symptoms Began _____________________ Date of Surgery _____________________

Have you EVER been diagnosed as having any of the following conditions? Please circle.

Cancer
Bleeding Disorder
Thyroid problems
Stroke
Osteoporosis

High Blood Pressure
Asthma
Kidney problems
Seizures
Osteoarthritis

Heart problems
Hepatitis
Depression
Rheumatoid Arthritis

Circulation problems
Tuberculosis
Diabetes
Chemical Dependency

Blood Clots
Stomach Ulcers
Multiple Sclerosis

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date.

Do you have allergies:  Y    N    If yes, please specify __________________________________________________________________

Please list any medications you are currently taking (prescription and over the counter). If you have a list, we would be happy to photocopy if for you.

Please circle any of the following symptoms you are experiencing.

nausea/vomiting
fever/chills/sweats
loss of vision
sexual difficulties
excessive bleeding
heart racing in your chest
urinary incontinence
weight loss/gain
blood in stools

fatigue
numbness or tingling
eye redness
hearing problems
difficulty breathing
difficulty swallowing
blood in urine
bowel/bladder irregularities
menstrual irregularities

dizziness/lightheadedness
seizures
skin rash
joint/muscle swelling
regular cough
heartburn/indigestion
pregnant or think you might be
abdominal pain/problems

night pain or night sweats
tremors
double vision
problems sleeping
easy bruising
arm/leg swelling
post menopause
stress at home or work

If you circled any of the above, are you under a physician’s care for this/these conditions?  Y    N

Patient Signature ________________________________________  Thank you for taking time to complete this questionnaire.
PATIENT DEMOGRAPHIC INFORMATION

Date __________________________

First ____________________ MI _______ Last _____________________ DOB ____________ Age _______

Male / Female Married / Single / Widowed / Child Soc. Sec. # __________________________

Home Address ________________________________________________________________

City __________________________ State _______ Zip ____________ Email __________________________

Home# __________________________ Cell# __________________________ Work# __________________________

Employer __________________________ Occupation __________________________

Emergency Contact __________________________ Phone# __________________________

How did you hear about our office? __________________________________________________

IF PATIENT IS A MINOR:

Father: Name __________________________________________________ Phone# __________________________

Mother: Name __________________________________________________ Phone# __________________________

INSURANCE INFORMATION

Primary Insurance __________________________ Policy Holder Name __________________________

Policy Holder DOB __________________________ Relationship __________________________

Secondary Insurance __________________________ Policy Holder Name __________________________

Policy Holder DOB __________________________ Relationship __________________________

HOME ADDRESS OF POLICY HOLDER if different than patient’s __________________________

________________________________________________________________________

Is this a liability injury? Yes ☐ No ☐ If yes, please check one: Worker’s Comp ☐ Auto ☐ Other ☐

Claim#: __________________________ Contact Person __________________________ Phone __________________________

Are you being represented by an attorney? Yes ☐ No ☐

If yes:
Attorney Name ____________________________________________________________ Phone __________________________

Address ____________________________________________________________

I acknowledge that I have reviewed the information listed and confirm that there are no changes to my demographic and insurance information.

Initials _________ Date _______________ Initials _________ Date _______________ Initials _________ Date _______________

Initials _________ Date _______________ Initials _________ Date _______________ Initials _________ Date _______________
Welcome to Rock Valley Physical Therapy

Thank you for choosing Rock Valley and providing us the opportunity to work with you. We hope to exceed your expectations and assist you in achieving your goals.

**Notice of Privacy Practices:**
I acknowledge being offered Rock Valley Physical Therapy’s Notice of Privacy Practices pamphlet. I have initialed here to indicate that I understand my rights through HIPAA and that I am declining this pamphlet. (Initial Here) _________

**Authorized Person(s):**
I authorize you to speak to ________________________________
______________________________
______________________________, regarding my account and/or treatment.

By checking the box, I indicate that I do NOT want my Primary Care Physician (PCP) contacted regarding my care: ☐

**Authorization to Release Information:**
I authorize the release of any medical or any other information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Rock Valley Physical Therapy.

**Financial Responsibility:**
I understand that insurance billing is a service provided as a courtesy and that I am, at all times, financially responsible to Rock Valley Physical Therapy. It is my responsibility to notify Rock Valley Physical Therapy of any changes in my health care insurance coverage. If the submitted charges or any part of them are denied for payment, I am responsible for the balance. I request that payment of my services be made on my behalf to Rock Valley Physical Therapy. I understand that by signing this form, I am accepting financial responsibility, as explained above, for payment of the balance of all medical services. I also understand that Rock Valley Physical Therapy collects for copayments at the time of service.

**Supply Items:**
I understand that Rock Valley Physical Therapy may, during the course of treatment, recommend purchase of a supply item. Supply items may or may not be covered under my insurance plan. I understand that it is my financial responsibility to pay for any item in full if it is not covered under my insurance plan.

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

_________________________________________  _______________________
Patient or Responsible Party                                Date

Home Address of Responsible Party if different than the Patient:

________________________________________________________________________________________________

Non-Discrimination Policy:
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 at (309)-743-2070. TDD/Relay Iowa.