CARE CONNECTIONS

LOWER EXTREMITY

NAME _____ DATE _____

TIME _____ AM/PM ❒ Initial Visit ❒ Discharge Visit

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 1/2 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

(Applies 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 mildly disturbed (1–2 hrs. sleepless).
❒ My sleep is moderately disturbed (2–3 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.

ACUITY *(Answer on initial visit.)*

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

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.*

Please complete opposite side

PAIN INDEX

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

No Pain ——————————————— Worst Pain Imaginable

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)

■ 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: _____

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Rock Valley
PHYSICAL THERAPY

PATIENT HISTORY QUESTIONNAIRE - PT

Date _____

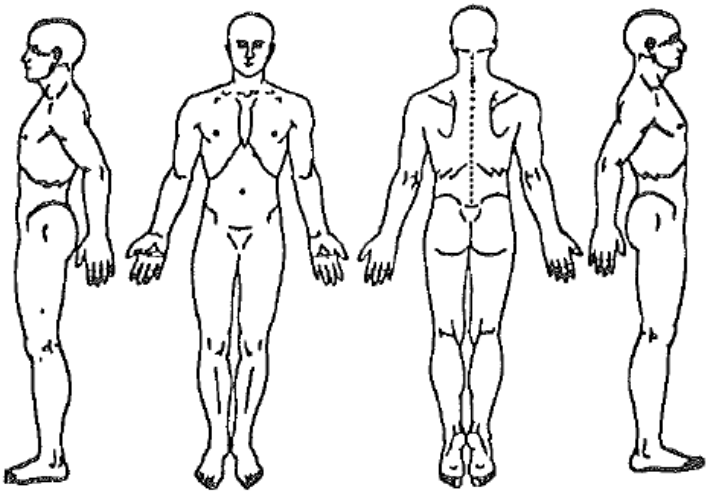
Name _____ DOB _____ Age _____ Height _____ Weight _____

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 _____



Indicate on the diagrams, 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

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

Cancer	High Blood Pressure	Heart problems	Circulation problems	Blood Clots
Bleeding Disorder	Asthma	Hepatitis	Tuberculosis	Stomach Ulcers
Thyroid problems	Kidney problems	Depression	Diabetes	Multiple Sclerosis
Stroke	Seizures	Rheumatoid Arthritis	Chemical Dependency	
Osteoporosis	Osteoarthritis	COPD/Emphysema	Tobacco use: Y N Amt/day: _____	

Other _____

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	fatigue	dizziness/lightheadedness	tremors
fever/chills/sweats	numbness or tingling	seizures	double vision
loss of vision	eye redness	skin rash	problems sleeping
sexual difficulties	hearing problems	joint/muscle swelling	easy bruising
excessive bleeding	difficulty breathing	regular cough	arm/leg swelling
heart racing in your chest	difficulty swallowing	heartburn/indigestion	post menopause
urinary incontinence	blood in urine	pregnant or think you might be	stress at home or work
weight loss/gain	bowel/bladder irregularities	abdominal pain/problems	
blood in stools	menstrual irregularities	night pain or night sweats	

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.*

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PHYSICAL THERAPY

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 _____

Making Better Lives.
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PHYSICAL THERAPY

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.