

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.

**DRIVING**

- I can drive my car or travel without any extra symptoms.
- I can drive my car or travel as long as I want with slight symptoms.
- I can drive my car or travel as long as I want with moderate symptoms.
- I cannot drive my car or travel as long as I want because of moderate symptoms.
- I can hardly drive at all or travel because of severe symptoms.
- I cannot drive my car or travel at all.

**LIFTING**

- I can lift heavy weights without extra symptoms.
- I can lift heavy weights, but it gives extra symptoms.
- My symptoms prevent me from lifting heavy weights, but I manage if they are conveniently positioned. (e.g. on a table)
- My symptoms prevent me from lifting heavy weights, but I manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

**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 using 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*

## PAIN INDEX

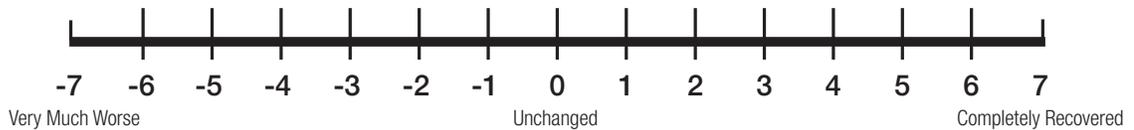
Please indicate the worst your pain has been in the last 24 hours on the scale below

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: \_\_\_\_\_

Date \_\_\_\_\_

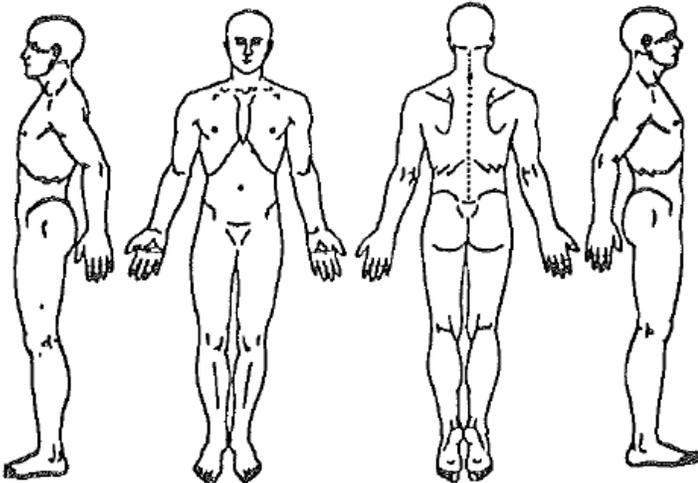
Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

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.*



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.

# Rock Valley 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.