Making Better Lives.
**Rock Valley**
PHYSICAL THERAPY

# PATIENT HISTORY QUESTIONNAIRE - PT

Date _____

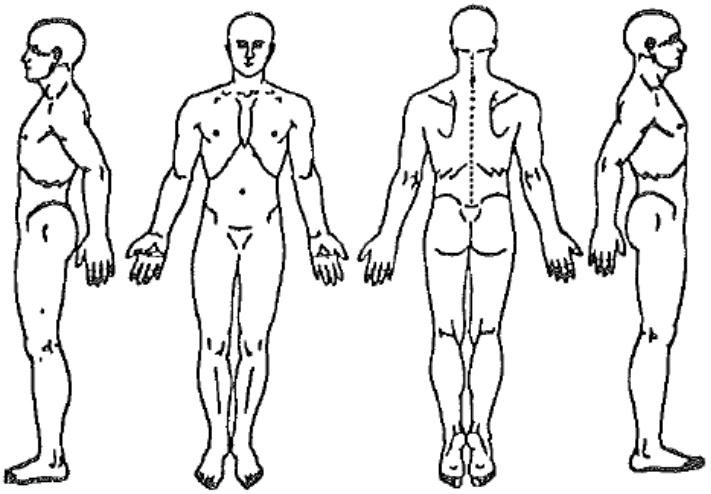
Name _____ DOB _____ Age _____ Height _____ Weight _____

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.*

Making Better Lives.
Rock Valley
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.
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.