ROCK VALLEY
PHYSICAL THERAPY
*Making Better Lives.*

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 __________

Email __________________________________________ ☐ I do not wish to receive Rock Valley newsletter

Patient Employed by ______________________________________ Occupation _______________

Business Address _________________________________________________________

City __________________ State ________ Zip Code ___________ Business Phone ______________

Name of Spouse _________________________ **Soc. Sec. #** _______________ **DOB** _____________

Spouse Employed by ______________________________________ Business Phone ______________

Emergency Contact _______________________________________ Phone ____________________

**IF PATIENT IS INSURED THROUGH A PARENT, COMPLETE THIS SECTION**

FATHER: Name __________________________________________ **DOB** ______________________

Employer __________________________________ Employer Phone ___________________

MOTHER: Name __________________________________________ **DOB** ______________________

Employer __________________________________ Employer Phone ___________________

HOME ADDRESS OF PARENT(S) if different than patient's ____________________________________

________________________________________________________ Phone ____________________

**INSURANCE INFORMATION**

Primary __________________________________ Secondary __________________________________

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:

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? ______________________________

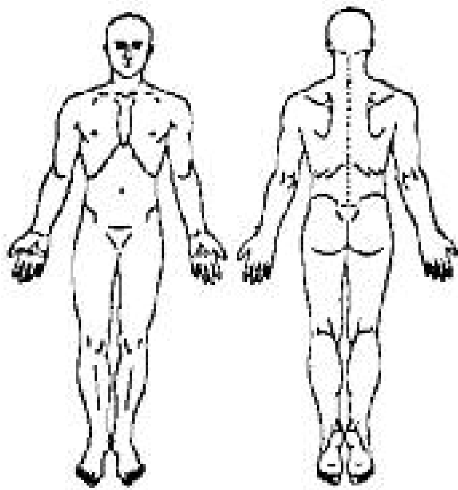
______________________________ Date symptoms began ______________

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

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

# MEDICAL SCREENING QUESTIONNAIRE

Name ______________________________ Date ______________

| | Question | | |
|---|---|---|---|
| 1. | Do you have any ongoing disease process such as diabetes, cancer, osteoporosis, or hypertension? | Y | N |
| 2. | Have you recently (last 6 months) lost more than 10 pounds without dieting or change in exercise habits? | Y | N |
| 3. | Are you experiencing any bowel or bladder irregularities? | Y | N |
| 4. | Are you experiencing any abdominal pain or problems? | Y | N |
| 5. | Are you experiencing any rectal bleeding? | Y | N |
| 6. | Are you experiencing any menstrual irregularities? | Y | N |
| 7. | If you answered yes to any question from 3 thru 6, are you under a physician's care for this/these problem(s)? | Y | N |
| 8. | Do you experience night pain that awakens you or night sweats? | Y | N |
| 9. | Do you feel weakness in your legs during walking? | Y | N |
| 10. | Are you experiencing any numbness in your buttocks or genital region? | Y | N |
| 11. | Has all treatment for your back made your symptoms worse? | Y | N |
| 12. | Do you get pain at the tip of your tailbone? | Y | N |
| 13. | Does your entire leg (front, back, and sides) ever become painful? | Y | N |
| 14. | Does your entire leg (front, back, and sides) ever become numb? | Y | N |
| 15. | Does your whole leg ever give way? | Y | N |
| 16. | Has there been any time, in the last year or during this episode, in which you have had very little back pain? | Y | N |
| 17. | Have you had to report to a hospital emergency room because of back pain? | Y | N |
| 18. | Have you ever taken cortisone or other steroids, either orally or by injection? | Y | N |
| 19. | Are there any other symptoms or concerns that have not been addressed in this questionnaire? | Y | N |

If yes, explain. ______________________________

______________________________

______________________________

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 (inapropriate 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 ______________________

# The Activities-specific Balance Confidence (ABC) Scale*

**Instructions to Participants:**
For each of the following, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale form 0% to 100%. If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as it you were using these supports. If you have any questions about answering any of these items, please ask the administrator.

## The Activities-specific Balance Confidence (ABC) Scale*

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10 20 30 40 50 60 70 80 90 100%
no confidence completely confident

"How confident are you that you will not lose your balance or become unsteady when you…

1. …walk around the house? ____%
2. …walk up or down stairs? ____%
3. …bend over and pick up a slipper from the front of a closet floor ____%
4. …reach for a small can off a shelf at eye level? ____%
5. …stand on your tiptoes and reach for something above your head? ____%
6. …stand on a chair and reach for something? ____%
7. …sweep the floor? ____%
8. …walk outside the house to a car parked in the driveway? ____%
9. …get into or out of a car? ____%
10. …walk across a parking lot to the mall? ____%
11. …walk up or down a ramp? ____%
12. …walk in a crowded mall where people rapidly walk past you? ____%
13. …are bumped into by people as you walk through the mall?____%
14. … step onto or off an escalator while you are holding onto a railing? ____%
15. … step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ____%
16. …walk outside on icy sidewalks? ____%

*Powell, LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. *J Gerontol Med Sci* 1995; 50(1): M28-34