



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? _____

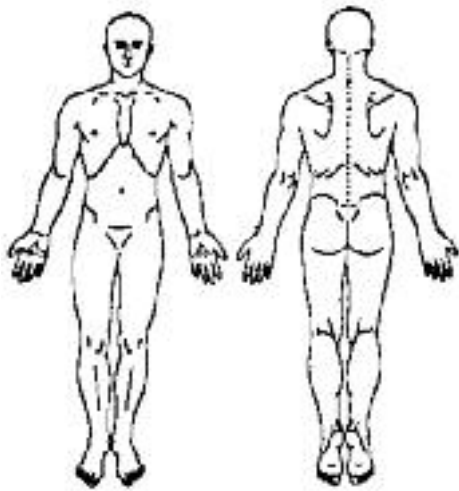
What caused your symptoms to begin? _____

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

Thank you for taking the time to complete this questionnaire.



MEDICAL SCREENING QUESTIONNAIRE

Name _____ Date _____

- | | | |
|----------------------------------------------------------------------------------------------------------------------------|---|---|
| 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?
If yes, explain. _____ | Y | N |



ROCK VALLEY
 PHYSICAL THERAPY
Making Better Lives.

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 (inappropriate 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 _____

Dizziness Handicap Inventory

Name: _____ DOB: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer “yes”, “no” or “sometimes” to each question.
Answer each question as it applies to your dizziness or unsteadiness only.

ITEM	QUESTION	P	E	F	Y	N	S
1	Does looking up increase your problem?	P					
2	Because of your problem, do you feel frustrated?	E					
3	Because of your problem, do you restrict your travel for business or recreation?	F					
4	Does walking down the aisle of a supermarket increase your problem?	P					
5	Because of your problem, do you have difficulty getting into or out of bed?	F					
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or to parties?	F					
7	Because of your problem, do you have difficulty reading?	F					
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P					
9	Because of your problem, are you afraid to leave your home without having someone accompany you?	E					
10	Because of your problem, are you embarrassed in front of others?	E					
11	Do quick movements of your head increase your problem?	P					
12	Because of your problem, do you avoid heights?	F					
13	Does turning over in bed increase your problem?	P					
14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	F					
15	Because of your problem, are you afraid people may think you are intoxicated?	E					
16	Because of your problem, is it difficult for you to walk by yourself?	F					
17	Does walking down a sidewalk increase your problem?	P					
18	Because of your problem, is it difficult for you to concentrate?	E					
19	Because of your problem, is it difficult for you to walk around the house in the dark?	F					
20	Because of your problem, are you afraid to stay at home alone?	E					
21	Because of your problem, do you feel handicapped?	E					
22	Has your problem placed stress on your relationship with members of your family or friends?	E					
23	Because of your problem, are you depressed?	E					
24	Does your problem interfere with your job or household responsibilities?	F					
25	Does bending over increase your problem?	P					
					X	X	X
					4	0	2
=							
TOTAL							

P _____ E _____ F _____

100-70= severe perception of having a handicap, 69-40= moderate perception of handicap, 39-0= low perception of handicap