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 ____

ROCK VALLEY
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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? ____

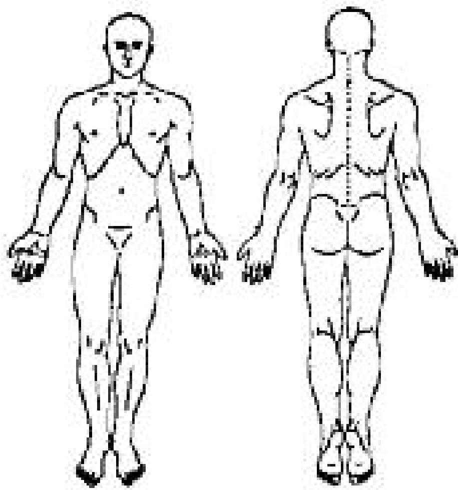
____ Date symptoms began ________________

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	Y	N
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

____

____

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 ______________________

Name: ____ Date: _____/ _____/_____

1. Do you usually experience *pressure* in the lower abdomen?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

2. Do you usually experience *heaviness or dullness* in the pelvic area?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?

___ NO ___ YES

<u>If yes</u>, how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?

___ NO ___ YES

<u>If yes</u>, how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

5. Do you usually experience a feeling of incomplete bladder emptying?

___ NO ___ YES

<u>If yes</u>, how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

6. Do you ever have to push up on a bulge in the vaginal area with your finger to start or complete urination?

___ NO   ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all   __ **2** – Somewhat   __ **3** – Moderately   __ **4** – Quite a bit

---

7. Do you feel you need to strain too hard to have a bowel movement?

___ NO   ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all   __ **2** – Somewhat   __ **3** – Moderately   __ **4** – Quite a bit

---

8. Do you feel you have not completely emptied your bowels at the end of the bowel movement?

___ NO   ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all   __ **2** – Somewhat   __ **3** – Moderately   __ **4** – Quite a bit

---

9. do you usually lose stool beyond your control if your stool is well formed?

___ NO   ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all   __ **2** – Somewhat   __ **3** – Moderately   __ **4** – Quite a bit

---

10. Do you usually loose stool beyond your control if your stool is loose or liquid?

___ NO   ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all   __ **2** – Somewhat   __ **3** – Moderately   __ **4** – Quite a bit

---

11. Do you usually lose gas from the rectum beyond your control?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

12. Do you usually have pain when you pass your stool?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

14. Does a part of your bowel ever pass though the rectum and bulge outside during or after a bowel movement?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

15. Do you usually experience frequent urination?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

16. Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

17. Do you usually experience urine leakage related to coughing, sneezing, or laughing?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

18. Do you usually experience small amounts of urine leakage (that is, drops)?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

19. Do you usually experience difficulty emptying your bladder?

___ NO ___ YES

<u>If yes,</u> how much does this bother you?

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

20. Do you usually experience *pain or discomfort* in the lower abdomen or genital region?

___ NO ___ YES **<u>If yes,</u> how much does this bother you?**

__ **1** – Not at all __ **2** – Somewhat __ **3** – Moderately __ **4** – Quite a bit

---

Thank you for taking the time to complete this questionnaire

KEEPING A RECORD OF BLADDER FUNCTION

Please complete a bladder log every day for 2 days and bring it to your appointment.
Please do at least one day on working day.

The main purpose of a bladder log is to document how your bladder functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns. At first, the log is used as an evaluation tool. Later, it will be used to measure your progress on bladder retraining or leakage episodes.
Your log will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of day exactly what happened in the morning.

INSTRUCTIONS

Column 1 – Time of Day

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold. Select the hour block that corresponds with the time of day you are recording information.

Column 2 – Type & Amount of Fluid & Food Intake

- Record the type and amount of **fluid** you drank
- Record the type and amount of **food** you ate
- Record when you woke up for the day and the hour you went to sleep

Column 3 – Amount Voided (Urinated): Two methods

Record the time of day and the amount voided. Use the first method unless directed by your health care provider to directly measure or count urine amounts. Record a bowel movement with a BM at the appropriate time.

1. Place a S, M, L, in the box at the corresponding time interval each time you urinate.
   S- SMALL= seemed like a small amount, or urinated "just in case".
   M- MEDIUM = seemed like an 8 ounce measuring cup would run over.
   L- LARGE = seemed like the amount you urinate when you first wake up in the morning.
2. If you have difficulty gauging the amount of urine, you may record the seconds by counting "one-one thousand" (this equals one second) while emptying your bladder. Record the number of seconds it took you to void.

Column 4 – Amount of Leakage

Record the amount of urine loss at the time it occurred.

S- SMALL= drop or two of urine
M- MEDIUM = wet underwear
L- LARGE = wet outerwear or floor

Column 5 – Was Urge Present

Describe the urge sensation you had as:

1- MILD = first sensation of need to go
2- MODERATE = stronger sensation or need
3- STRONG = need to get to a toilet, move aside!

Column 6 – Activity with Leakage Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, bent over, lifted something or had strong urge.

Comments – (at the bottom of the log table) Special problems and new or changes in medication are recorded here. If a pad change was ne [illegible] he day at the bottom of the page.

Daily Voiding Log Sample

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided in Ounces or S /M /L or seconds	Amount of Leakage S /M /L	Was Urge Present 1/ 2/ 3	Activity with Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am	Woke up at 6:45 am	L		3	
7:00 am	Coffee, bagel				
8:00 am			M		Fast walking
9:00 am	Apple	M		2	
10:00 am					
11:00 am		S		1	Key in the door
NOON	Tuna sandwich, milk, pear				
1:00 pm					
2:00 pm		M		2	
3:00 pm	Tea, cookies		S		Running water
4:00 pm					
5:00 pm					
6:00 pm	Chicken, corn pudding, salad, apple juice	M		3	
7:00 pm					
8:00 pm			S	3	
9:00 pm					
10:00 pm	To bed at 10:30	M		3	
11:00 pm					

Comments: week before period_______________________________ Number of pads: 2__

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ROCK VALLEY
PHYSICAL THERAPY
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DAILY VOIDING LOG

Name____________________________ **Date**________________

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided Ounces, S/ M/ L or Seconds	Amount of Leakage S/ M/ L	Was Urge Present 1/ 2/ 3	Activity with Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
NOON					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments____

Number of pads used today ________________

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