DYERSVILLE	MANCHESTER	DUBUQUE	DUBUQUE- DOWNTOWN
1129 11th St SE, Suite A	107 S. 11th St, Suite 1	3080 N Cascade Rd.	245 Railroad Ave. Ste F-2
Dyersville, IA 52040	Manchester, IA 52057	Dubuque, IA 52003	Dubuque, IA 52003
Tel: 563-875-8615	Tel: 563-927-1799	Tel: 563-231-9900	Tel: 563-231-9900

Patient Information

First Name:	MI:	Last Name:
Address:	City: State: Zip Code:	
Cell Phone:	Other Phone:	Married: Single: Other:
DOB: _____ /_____ /______	Email:	
Emergency Contact:	Relationship to Patient:	Phone:

Insurance Policyholder's Information

Self

Policyholder's Name:	DOB:	Phone:
Policyholder's Employer:		

Employment

Employment Status:	Full-Time	Part-Time	Retired	Unemployed	Student	Other
Employer Name:						
Employer Address:						

How did you hear about us?

Doctor	Family Member/ Friend	Insurance	Newspaper	Internet Search	Other
Please specify:					
Have you been previously treated at Physical Therapy Solutions? Yes No					

Accident Information (If Applicable)

Accident Type: Auto Other:	Claim #:

CONSENT FORM

**** It is important that the patient checks his/her physical therapy benefits with his/her insurance company, as all policies have different benefits and limitations****

FINANCIAL RESPONSIBILITY

I realize my insurance is billed as a courtesy. I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance, unless my insurance carrier has a provider agreement with Physical Therapy Solutions, P.C.. ****There will be a $25.00 charge for all returned checks.****

ASSIGNMENT OF BENEFITS & CONSENT FOR TREATMENT

I consent to the plan of care and treatment by the therapist and/or his/her assistants/interns. I hereby authorize payment of medical benefits directly to Physical Therapy Solutions for services and/or supplies furnished. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I further authorize the release of any medical information required to process my insurance claim. If this is a work comp claim, the authorization extends to my employer, work comp insurance company, adjuster, occupational health specialist, rehabilitation specialist, case manager or representative of my employer. I permit a copy of this authorization to be as valid as the original.

Athletes and/or students: I authorize the release of my treatment status and/or restrictions from school PE class and/or sporting activities to coaches, athletic trainers, and/or PE teachers by my physical therapist when it is necessary.

==

You must notify receptionist if you have had any previous physical therapy at another facility during this current calendar year. Failure to do so may result in denial of payment by your insurance company.

_______ **No, I have not received physical therapy, in-home, or skilled nursing treatment this current year.**
_______ **Yes, I have received physical therapy, in-home, or skilled nursing treatment this current year.**

If you have answered **yes** to the above question, please fill in information below regarding your treatment:

Number of treatment(s) _______ Treatment date(s): _________________________

CANCEL/NO-SHOW POLICY

Physical Therapy Solutions considers Cancellation of Your Appointment or Not Showing for Your Appointment a serious issue, because it can make the difference between whether you will or will not attain your treatment goals.

- **We appreciate at least 2 hours advance notice of cancellation of appointment.**

I acknowledge that I have been given the opportunity to review and offered a copy of the PTS "Notice of Privacy Practices"

THIS CERTIFIES THAT I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATIONS AND I AGREE TO THEM.

By my written or e-signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

____ _________________________
Patient Signature Date

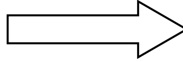
____ _________________________
Staff Signature Date

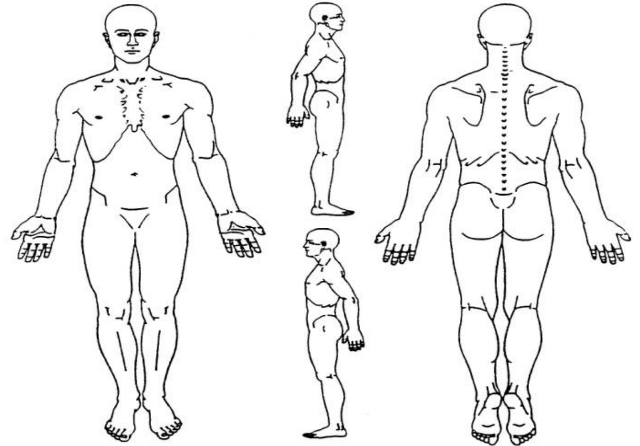
PHYSICAL THERAPY SOLUTIONS

Intake Questionnaire

Name: ______________________________
Date: ______________________________
Injured side: Left Right Both
Referring Physician: _________________
Family Physician: ___________________
Date symptoms started:_______________
How did the injury occur: _____________
____
____

*Please select where you are experiencing symptoms.





RATE YOUR PAIN: (Please select the best number on the scale.)

AT BEST	**No Pain**	**0 1 2 3 4 5 6 7 8 9 10**	**Unbearable**
AT WORST	**No Pain**	**0 1 2 3 4 5 6 7 8 9 10**	**Unbearable**

Health History:

Mark one box for each item:	**No**	**Yes**	**Explain:**
Bleeding Disorder/Blood Clots	☐	☐	
Diabetes	☐	☐	
Fibromyalgia	☐	☐	
Heart Condition	☐	☐	
High Blood Pressure	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Allergies	☐	☐	
Cancer	☐	☐	
Surgical History	☐	☐	
Smoker/tobacco	☐	☐	
Pacemaker	☐	☐	
Allergic to latex	☐	☐	
Pregnant	☐	☐	
Osteoporosis	☐	☐	
Have you fallen in the past year?	☐	☐	
Do you have bowel or bladder problems?	☐	☐	
Do you have dizziness/vertigo?	☐	☐	

Mental Health: ☐ Anxiety ☐ Depression ☐ Other: ____

MEDICATIONS: (For this current problem.)

____

****Other medications you take often play a role in your physical therapy treatment. Please list all of your current medications or provide a list to our front office staff and they will make a copy to place in your chart for your therapist to review.*

Previous treatments for current pain:

Chiropractic care ☐
Orthotics ☐
Splints/braces ☐
Injections ☐
Surgery ☐
Physical Therapy ☐
Other, please explain:_______________________

Circle all activities that you have difficulty with:

Walking	Squatting
Sitting	Reaching Overhead
Standing	Reaching behind Back
Sleeping	Pushing/Pulling
Lifting	Going up/down Stairs
Carrying	Getting in/out of a Chair
Working	Driving

Other, please explain____________________________

Patient Name: ______________________________________ DOB: _________ Date: ___________

The Dizziness Handicap Inventory (DHI)

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 as it applies to your dizziness or unsteadiness only.

#	Question						
1	Does looking up increase your problem?		NO		Sometimes		Yes
2	Because of your problem, do you feel frustrated?		NO		Sometimes		Yes
3	Because of you problem, do you restrict your travel for business or recreation?		NO		Sometimes		Yes
4	Does walking down the aisle of a supermarket increase your problem?		NO		Sometimes		Yes
5	Because of your problem, do you have difficulty getting into or out of bed?		NO		Sometimes		Yes
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing or to parties?		NO		Sometimes		Yes
7	Because of your problem, do you have difficulty reading?		NO		Sometimes		Yes
8	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?		NO		Sometimes		Yes
9	Because of your problem, are you afraid to leave your home without someone accompanying you?		NO		Sometimes		Yes
10	Because of your problem, have you been embarrassed in front of others?		NO		Sometimes		Yes
11	Do quick movements of your head increase your problem?		NO		Sometimes		Yes
12	Because of your problem, do you avoid heights?		NO		Sometimes		Yes
13	Does turning over in bed increase your problem?		NO		Sometimes		Yes
14	Because of your problem, is it difficult for you to do strenuous housework or yard work?		NO		Sometimes		Yes
15	Because of your problem, are you afraid people may think you are intoxicated?		NO		Sometimes		Yes
16	Because of your problem, is it difficult for you to walk by yourself?		NO		Sometimes		Yes
17	Does walking down a sidewalk increase your problem?		NO		Sometimes		Yes
18	Because of your problem, is it difficult for you to concentrate?		NO		Sometimes		Yes
19	Because of your problem, is it difficult for you to walk around your house in the dark?		NO		Sometimes		Yes
20	Because of your problem, are you afraid to stay home alone?		NO		Sometimes		Yes
21	Because of your problem, do you feel handicapped?		NO		Sometimes		Yes
22	Has your problem placed stress on you relationships with members of your family or friends?		NO		Sometimes		Yes
23	Because of your problem, are you depressed?		NO		Sometimes		Yes
24	Does your problem interfere with your job or household responsibilities?		NO		Sometimes		Yes
25	Does bending over increase your problem?		NO		Sometimes		Yes

Scoring Instructions

No = 0 Sometimes = 2 Yes = 4

16-34 points - Mild Handicap

26-53 points - Moderate Handicap

54 + points - Sever Handicap

Score: _____________