Physical Therapy Solutions
Solutions for an ACTIVE life

DYERSVILLE	MANCHESTER	DUBUQUE	DUBUQUE- DOWNTOWN
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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.

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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

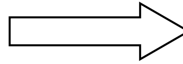
____ _________________________
Staff Signature Date

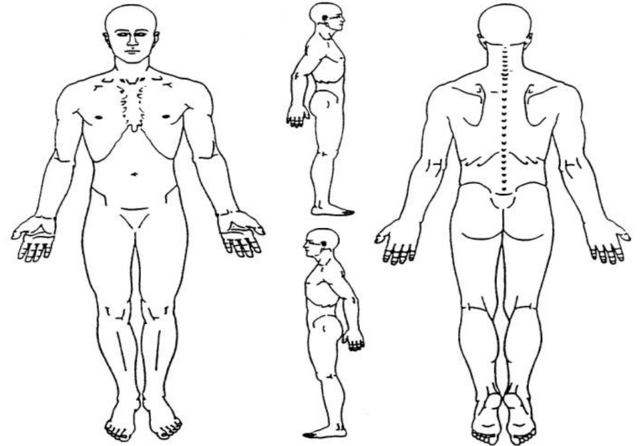
PHYSICAL THERAPY SOLUTIONS

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______________________________

Modified Oswestry Low Back Pain Disability Questionnaire

Name:____ Date: _____/_____/______

Please Read:
This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one** box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

Section 1 – Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Pain medication has no effect on the pain

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking
- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting
- ☐ I can it in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 mins.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 mins.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all

Section 8 – Social Life
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Section 9 – Traveling
- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking
- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job/homemaking chores.