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

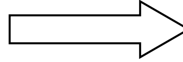
____ _______________________
Staff Signature Date

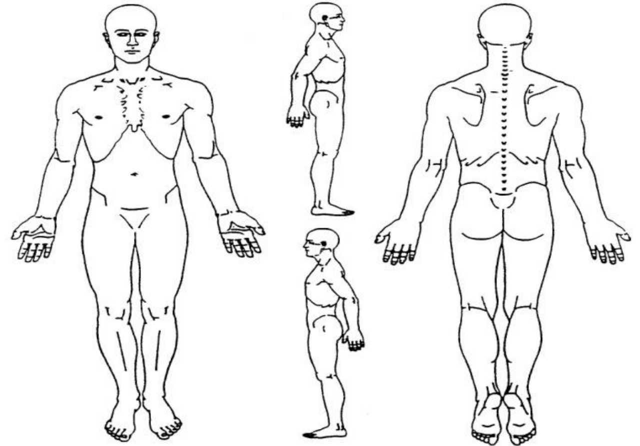
PHYSICAL THERAPY SOLUTIONS

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_____________________________

Lower Extremity Functional Index

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

(Check one number on each line)

Activities	Extreme Difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS					

Score variation ± 6 LEFTS points
MDC & MCID = 9 LEFS points

Score _____/80