Physical Therapy Solutions
Solutions for an ACTIVE life

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
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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 #:

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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

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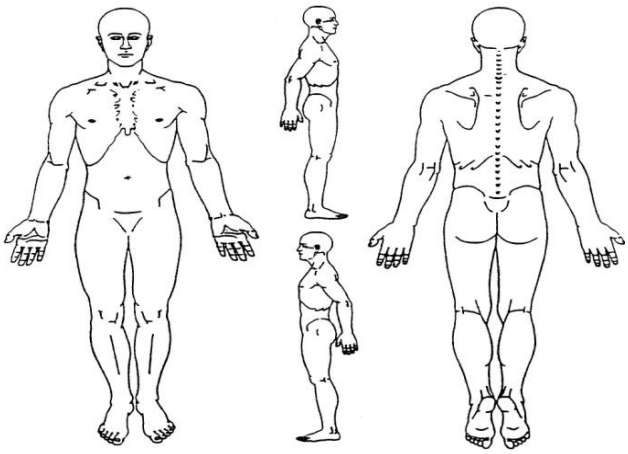
PHYSICAL THERAPY SOLUTIONS

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_____

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may not be calculated if there is greater than 1 missing item.

Score: _____