



Physical Therapy Solutions
Solutions for an ACTIVE life

DYERSVILLE
1129 11th St SE, Suite A
Dyersville, IA 52040
Tel: 563-875-8615

MANCHESTER
107 S. 11th St, Suite 1
Manchester, IA 52057
Tel: 563-927-1799

DUBUQUE
3080 N Cascade Rd.
Dubuque, IA 52003
Tel: 563-231-9900

DUBUQUE- DOWNTOWN
245 Railroad Ave. Ste F-2
Dubuque, IA 52003
Tel: 563-231-9900

Patient Information			
First Name:	MI:	Last Name:	
Address:			City: State: Zip Code:
Cell Phone:	Other Phone:		Married: <input type="checkbox"/> Single: <input type="checkbox"/> Other: <input type="checkbox"/>
DOB: _____ / _____ / _____	Email:		
Emergency Contact:	Relationship to Patient:	Phone:	

Insurance Policyholder's Information		
<input type="checkbox"/> Self		
Policyholder's Name:	DOB:	Phone:
Policyholder's Employer:		

Employment	
Employment Status:	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Other
Employer Name:	
Employer Address:	

How did you hear about us?	
<input type="checkbox"/> Doctor <input type="checkbox"/> Family Member/ Friend <input type="checkbox"/> Insurance <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet Search <input type="checkbox"/> Other	
Please specify:	
Have you been previously treated at Physical Therapy Solutions? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Accident Information (If Applicable)	
Accident Type: <input type="checkbox"/> Auto <input type="checkbox"/> Other:	Claim #:



Physical Therapy Solutions
Solutions for an ACTIVE life

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



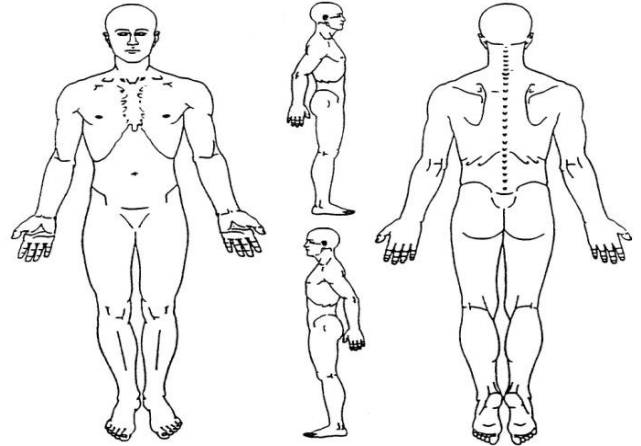
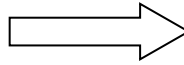
PHYSICAL THERAPY SOLUTIONS

Intake Questionnaire

Physical Therapy Solutions
Solutions for an ACTIVE life

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	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Surgical History	<input type="checkbox"/>	<input type="checkbox"/>	
Smoker/tobacco	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	
Allergic to latex	<input type="checkbox"/>	<input type="checkbox"/>	
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Have you fallen in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have bowel or bladder problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have dizziness/vertigo?	<input type="checkbox"/>	<input type="checkbox"/>	

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 _____

Name: _____

Date: _____

JAW FUNCTIONAL LIMITATION SCALE

For each of the items below, please indicate the level of limitation **during the last month**. If the activity has been completely avoided because it is too difficult, then circle '10'. If you avoid an activity for reasons other than pain or difficulty, then leave the item blank.

		No Limitation										Severe Limitation
1	Chew tough food	0	1	2	3	4	5	6	7	8	9	10
2	Chew hard bread	0	1	2	3	4	5	6	7	8	9	10
3	Chew chicken (for example, prepared in oven)	0	1	2	3	4	5	6	7	8	9	10
4	Chew crackers	0	1	2	3	4	5	6	7	8	9	10
5	Chew soft food (for example, macaroni, canned or soft fruits, cooked vegetables, fish)	0	1	2	3	4	5	6	7	8	9	10
6	Eat soft food requiring no chewing (for pudding, pureed food)	0	1	2	3	4	5	6	7	8	9	10
7	Open wide enough to bite from a whole apple	0	1	2	3	4	5	6	7	8	9	10
8	Open wide enough to bite into a sandwich	0	1	2	3	4	5	6	7	8	9	10
9	Open wide enough to talk	0	1	2	3	4	5	6	7	8	9	10
10	Open wide enough to drink from a cup	0	1	2	3	4	5	6	7	8	9	10
11	Swallow	0	1	2	3	4	5	6	7	8	9	10
12	Yawn	0	1	2	3	4	5	6	7	8	9	10
13	Talk	0	1	2	3	4	5	6	7	8	9	10
14	Sing	0	1	2	3	4	5	6	7	8	9	10
15	Putting on a happy face	0	1	2	3	4	5	6	7	8	9	10
16	Putting on an angry face	0	1	2	3	4	5	6	7	8	9	10
17	Frown	0	1	2	3	4	5	6	7	8	9	10
18	Kiss	0	1	2	3	4	5	6	7	8	9	10
19	Smile	0	1	2	3	4	5	6	7	8	9	10
20	Laugh	0	1	2	3	4	5	6	7	8	9	10

No Pain At All

Pain As Bad As It Could Be

0 _____ 10