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
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 #:

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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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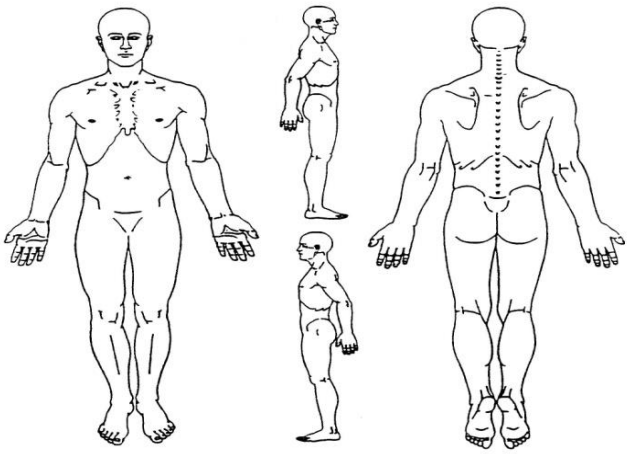
PHYSICAL THERAPY SOLUTIONS

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_____

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ❑ **I have no pain at the moment.**
- ❑ **The pain is very mild at the moment.**
- ❑ **The pain is moderate at the moment.**
- ❑ **The pain is fairly severe at the moment.**
- ❑ **The pain is very severe at the moment.**
- ❑ **The pain is the worst imaginable at the moment.**

SECTION 2 - PERSONAL CARE

- ❑ **I can look after myself normally without causing extra pain.**
- ❑ **I can look after myself normally, but it causes extra pain.**
- ❑ **It is painful to look after myself, and I am slow and careful.**
- ❑ **I need some help but manage most of my personal care.**
- ❑ **I need help every day in most aspects of self -care.**
- ❑ **I do not get dressed. I wash with difficulty and stay in bed.**

SECTION 3 – LIFTING

- ❑ **I can lift heavy weights without causing extra pain.**
- ❑ **I can lift heavy weights, but it gives me extra pain.**
- ❑ **Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.**
- ❑ **Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.**
- ❑ **I can lift only very light weights.**
- ❑ **I cannot lift or carry anything at all.**

SECTION 4 – WORK

- ❑ **I can do as much work as I want.**
- ❑ **I can only do my usual work, but no more.**
- ❑ **I can do most of my usual work, but no more.**
- ❑ **I can't do my usual work.**
- ❑ **I can hardly do any work at all.**
- ❑ **I can't do any work at all.**

SECTION 5 – HEADACHES

- ❑ **I have no headaches at all.**
- ❑ **I have slight headaches that come infrequently.**
- ❑ **I have moderate headaches that come infrequently.**
- ❑ **I have moderate headaches that come frequently.**
- ❑ **I have severe headaches that come frequently.**
- ❑ **I have headaches almost all the time.**

SECTION 6 – CONCENTRATION

- ❑ **I can concentrate fully without difficulty.**
- ❑ **I can concentrate fully with slight difficulty.**
- ❑ **I have a fair degree of difficulty concentrating.**
- ❑ **I have a lot of difficulty concentrating.**
- ❑ **I have a great deal of difficulty concentrating.**
- ❑ **I can't concentrate at all.**

SECTION 7 – SLEEPING

- ❑ **I have no trouble sleeping.**
- ❑ **My sleep is slightly disturbed for less than 1 hour.**
- ❑ **My sleep is mildly disturbed for up to 1-2 hours.**
- ❑ **My sleep is moderately disturbed for up to 2-3 hours.**
- ❑ **My sleep is greatly disturbed for up to 3-5 hours.**
- ❑ **My sleep is completely disturbed for up to 5-7 hours.**

SECTION 8 – DRIVING

- ❑ **I can drive my car without neck pain.**
- ❑ **I can drive as long as I want with slight neck pain.**
- ❑ **I can drive as long as I want with moderate neck pain.**
- ❑ **I can't drive as long as I want because of moderate neck pain.**
- ❑ **I can hardly drive at all because of severe neck pain.**
- ❑ **I can't drive my care at all because of neck pain.**

SECTION 9 – READING

- ❑ **I can read as much as I want with no neck pain.**
- ❑ **I can read as much as I want with slight neck pain.**
- ❑ **I can read as much as I want with moderate neck pain.**
- ❑ **I can't read as much as I want because of moderate neck pain.**
- ❑ **I can't read as much as I want because of severe neck pain.**
- ❑ **I can't read at all.**

SECTION 10 – RECREATION

- ❑ **I have no neck pain during all recreational activities.**
- ❑ **I have some neck pain with all recreational activities.**
- ❑ **I have some neck pain with a few recreational activities.**
- ❑ **I have neck pain with most recreational activities.**
- ❑ **I can hardly do recreational activities due to neck pain.**
- ❑ **I can't do any recreational activities due to neck pain.**

PATIENT NAME _____ **DATE** _____

SCORE _____ **[50]** **BENCHMARK -5 =** _____