PATIENT REGISTRATION

2519 Cove Avenue
La Grande, Oregon 97850
Phone: 541-962-0830 Fax 541-975-2720
Website: http://www.mountainvalleytherapy.biz

Name: ____ Date: ____________________
Last First MI

Patient Address: ____
Street City State Zip Code

Home Phone: ________________ Work : ____________________ Cell: ____________________

SS # ____________________ Birthdate: ______________________ Age: ______________

Sex: Female ___ Male ___ Emergency Contact: ______________________ Phone #: ______________

Person Responsible For Bill: Self ___ Attorney ___ Parent ___ Other ___ Phone #: ________________

Name: ____ Relationship: ________________
Address: ____

What area of the body are we treating?____
Referring Physician: ________________________________ Phone #: ____________________
Address: ____
Street City State Zip Code

You are responsible for checking your insurance regarding therapy benefits

Primary Insurance: ____________________ ID# __________________ Group # ______________
Insured Name: ____________________ Birthdate: __________ Relationship: Self __ Spouse __ Parent __

Secondary Insurance: ____________________ ID# __________________ Group # ______________
Insured Name: ____________________ Birthdate: __________ Relationship: Self __ Spouse __ Parent __

Have you had physical or occupational therapy in the last 12 months? No Yes Where? __________

Have you ever been or are you currently enrolled in Home Health? No Yes When? __________
Have you ever been or are you currently enrolled in Hospice? No Yes When? __________

Work Related Information: (If Applicable)
Date of Injury: ______________ Name of Employer At Time of Injury: ________________________
Address of Employer: ______________________________ Phone # ____________________
Insurance Company: ____________________ Address: ________________________________
Claim # : ______________________________ Phone # ________________________________
Adjuster: ______________________________ Name of Insured: ________________________

Auto Accident Information: (If Applicable)
Date of Injury: ________________ Insurance Company: ________________________________
Address: ___________________________________ Phone #: ________________________
Claim #: ________________ Adjuster: ________________ Name of Insured ________________

Attorney Information: (If Applicable)
Name: ________________________ Address: ________________________________
Phone # : ____

How were you referred to MVT? Physician (MD) ____ Friend/Family ____ Yellow Pages ____ Website/Internet ____
Newspaper ____ Facebook ____ Callback Program ____ Employee Referral ________________________
(Name of Employee)

Mountain Valley Therapy
2519 Cove Ave
La Grande, OR 97850
(541) 962-0830

Office Financial Policy

Patient Name: ______________________________ _____ Date:____________

- **Basic Policy:** Co-payments or your appropriate percentage according to your insurance benefit is expected at the time of service. We accept Visa & Mastercard payments as well as checks and cash. Be sure that you receive a receipt for any cash payment.

  _______ (initials)

- **For patients with worker's compensation or motor vehicle claims:** We will determine claim information before you start treatment. If, at anytime, your claim is denied or the benefit is exhausted, you will be responsible for any unpaid balances.

  _______ (initials)

- **For Patients with Private Insurance:** We will bill your insurance companies (both primary and secondary insurance) for your visits *as a courtesy to you.* We are a Medicare provider and will bill Medicare for you. We need a copy of your insurance card(s) in order to bill for you. You, as the patient, are responsible for knowing your physical therapy benefits.

  _______ (initials)

- **For patients without insurance:** The cost of the initial evaluation is due on the date of the first visit. Account balance will be paid at each visit unless a payment plan has been previously arranged with the billing department.

  _______ (initials)

- **Non-covered Services:** Any care or supplies not paid for by your existing insurance coverage will require *payment in full* at the time services are provided or upon notice of insurance claim denial.

  _______ (initials)

- **Missed Appointments:** In fairness to other patients and the therapists, we require at least **24 hours** notice to cancel appointments. You may be charged **$50** for missed appointments.

  _______ (initials)

- **Finance Charge:** If the patient has been billed for an unpaid balance and payment is not received within the next 30 days, a finance charge of 1.5% monthly interest or 18% annual interest will be applied to the remaining balance until paid in full. If your account should require the use of a collection agency, be advised that a processing fee of $11.95 will be charged to your balance.

  _______ (initials)

Statement of Financial Responsibility

I, the undersigned, have read the above and realize that all medical charges incurred by me or my dependents for services rendered are my financial responsibility. All court fees, attorney's fees, or other fees necessary to collect this amount are payable by me.

Signature: ____________________________________ Date:___________________

Life-time Authorization

I, ______________________________ authorize this facility to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Mountain Valley Therapy. I authorize this facility to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy. It is this facility's procedure to share Protected Health Information with referring medical providers. We will only exchange minimum necessary Protected Health Information for each transaction. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Signature: ________________________________ **Date: _________________**

Appointment Reminder Calls

I wish to be contacted in the following way(s):

Check all that apply		Is it okay to leave a message? (please circle)
___ Home Telephone	___________________	Yes or No
___ Work Telephone	___________________	Yes or No
___ Cell Phone	___________________	Yes or No
___ Other (please specify)_________________		

Notice of Privacy Practices

I understand and have been offered a Notice of Privacy Practices brochure that provides a more complete description of information uses and disclosures followed by Mountain Valley Therapy.

_______ (initials)

PATIENT QUESTIONNAIRE / HEALTH HISTORY

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

NAME: ____ DATE: _____________

HISTORY OF PRESENT CONDITION

1. When did your symptoms begin? ___________________
(Please indicate a specific date if possible)

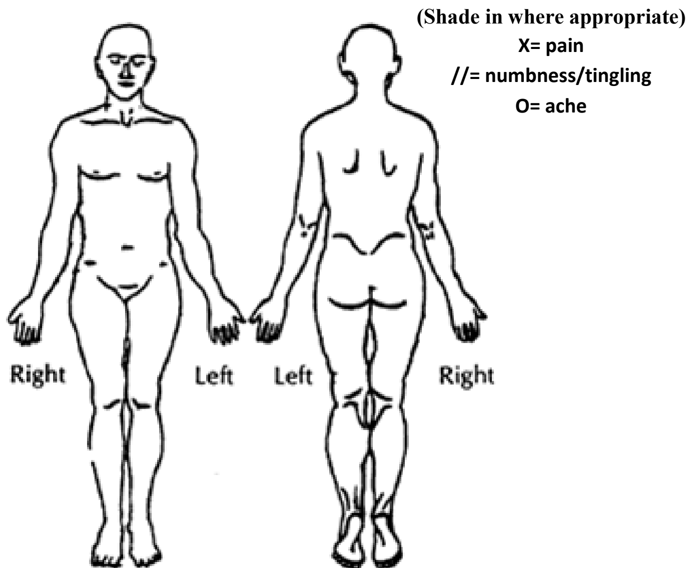
2. Check **ALL** that apply in regards to the onset of this episode?
□ Chronic
□ Gradual
□ New injury
□ Surgery for this incident
Date(s) of ___________________
□ Hospitalized for this incident
Date(s) of ___________________

3. Which of the following **best describes** how your injury occurred? (If your condition is post-surgical please indicate as per original injury)
□ Unknown
□ Lifting
□ Car accident: Date ________
□ Fall
□ Overuse (cumulative trauma)
□ During recreation/sports:
□ Trauma
□ Degenerative process
□ Dental appointment
□ An incident at work
□ Other ________________
____

4. **What are your symptoms?** ___________________________
____
____

5. Have you had similar symptoms in the past? □ Yes □ No
Date(s) _____________________

6a. Please indicate localized area of **pain** or **abnormal** sensation on the body chart below



6b. Pain/Symptoms Scale **AT WORST:**
0= No Pain/Symptoms, 10= Worst Pain/Symptoms

0 1 2 3 4 5 6 7 8 9 10

Pain/Symptoms **CURRENT**:

0 1 2 3 4 5 6 7 8 9 10

Pain/Symptoms **AT BEST**:

0 1 2 3 4 5 6 7 8 9 10

7. Nature of pain/symptoms (Check ALL that apply)
□ Burning □ Shooting □ Worse in morning
□ Sharp □ Numbness/tingling □ Worse in afternoon
□ Dull/achy □ Constant □ Worse at night
□ Throbbing □ Intermittent
□ Other ____

8. What aggravates your symptoms? (Check ALL that apply)
□ Sitting □ Sit to stand
□ Standing □ Bending
□ Walking □ Urinating (voiding)
□ Stairs-UP □ Lying down/Lying
□ Stairs-DOWN □ Cough/sneeze
□ Difficulty with being still □ Difficulty with moving
□ Turning
□ Other____

9. What **RELIEVES** your symptoms? (Check ALL that apply)
□ Bending □ Rising □ Lying
□ Sitting □ Standing □ Best when moving
□ Turning □ Walking □ Best when still
□ Other____

10. Have you received physical therapy for your current symptoms?
□ Yes □ No Date(s)_________________________

*11. Have you had a history of falls? □ Yes □ No
If yes, has it been in the last 12 months? □ Yes □ No
Date(s) ____________________________________

ASSISTED DEVISES/RESTRICTIONS

*12. What assisted device do you use to be mobile or use to walk?
□ None □ Standard walker □ Rolling Walker
□ Cane □ Four-point (quad) cane □ Side walker (hemi)
□ Wheelchair □ Other_____________

*13. Do you use a brace(s)? □ Yes □ No If so, type? _____________

*14. Do you have any restrictions on weight bearing while walking?
□ Yes □ No

SOCIAL BACKGROUND/GENERAL HEALTH

15. What is your current social/living situation? (check ALLthat apply)
□ Single □ Divorced □ Widower
□ Live with family □ Live with caregiver □ Live alone
□ Live at assisted living facility
□ Other____

16. What is your current living environment/what does it contain? (check ALLthat apply)
□ 1-Story □ 2-Story □ Condo/Apt □ Steps/Stairs
□ Shower Stall □ Combo bathtub/shower □Wheelchair ramp
□ Other____

17. How will you be getting to appointments?
□ Driven by self □ Driven by family □ Driven by caretaker
□ Medical transport services □ Other_____________________

18. Are you a caregiver? □ Yes □ No
If yes, check ALL that apply:
□ Spouse □ Child □ Parent □ Other ___________

19. What is your general health? □ Good □ Fair □ Poor
20. Are you a tobacco user? □ Yes □ No If yes, type? __________
21. Have you had any unexplained weight loss? □ Yes □ No

WORK HISTORY

22a. Name of Occupation________________________________

22b. Employment Status (Check ALL that apply):

□ Employed full time □ Retired
□ Employed part time □ Out of work
□ Light duty □ Homemaker
□ Other_________________

23a. Level of work-load (Check the ONE that best applies)

□ Not applicable □ Medium
□ Sedentary □ Heavy
□ Light □ Very heavy

23b. Physical activities at work (Check ALL that apply)

□ Not applicable □ Heavy lifting
□ Sitting □ Computer use
□ Standing □ Heavy equipment operation
□ Phone use □ Driving
□ Repetitive lifting □ Other_________________

ONLY FOR WORKMAN'S COMPENSATION

24. Date since last able to work: _________________________
25. Date at which you plan to return to work: _________________
26. Are you visiting us as part of Worker's Compensation?
□ Yes □ No
27. Is there any litigation pending? □ Yes □ No

MEDICATIONS

28. Please check any CURRENT medications you are taking and list the name, dosage, frequency and how administered or mark that you are currently using medication:

□ Not currently taking any medications

□ Prescription □ See List
Or please list: ____________________________________
____
____

□ Over the counter:____________________________________
____

□ Herbals/ Vitamins/Supplements:_________________________
____

*Do you have any emergency medication? (Nitroglycerin, inhaler)
□ Yes □ No If yes, please list: __________________
□ Other____

29. Have you had any of the following tests for this episode?
(Check ALL that apply)

□ None □ Bone Scan □ X-rays
□ CT scan □ Nerve Conduction Study □ MRI
□ Vestibular □ Other _________________

Results: ____

THERAPY GOALS

30. What have your symptoms prevented you from doing that you want to do again (example: walking, go back to work, holding your kids, dance, etc.) ____
____

31. What is motivating you to get better? ____________________
____

PAST MEDICAL HISTORY

32. Please check any of the following that you are and/or have been diagnosed with? (List any important information next to appropriate box)

□ No known significant past medical history to affect treatment
□ * □ Osteoarthritis: Where: ____________________________
* □ Rheumatoid: Where: _______________________________
□ Other____
□ * Osteoporosis: Where: _______________________________
□ * Fibromyalgia
□ * Cardiovascular Disease:
□ Heart attack: Date: _________________
□ Stent: Date: ______________
□ Pacemaker: Date ______________
□ Bypass surgery: Date: ______________
□ Congestive Heart Failure
□ Blood Clot (DVT) or circulation/vascular problems
□ Angina
□ Other____________________________________
□ * Blood pressure: □ Low □ High
□ * Diabetes: □ Type 1 □ Type 2
□ Allergies ____
□ *Surgical History (procedure/year, include implants/hardware)
____
____
□ History of Cancer (type, date, treatment) ___________________
____
□ *Current Infections (i.e. hepatitis, tuberculosis, etc.)___________
____
□ * Immunosuppression_________________________________
□ *Fracture (location/year of incident) ______________________
____
□ * Stroke/TIA (mini stroke) Date: _________________________
□ Neurological Disorders_________________________________
□ *Alzheimer's/Dementia
□ Brain Injury: Date:___________________________________
□ * Multiple Sclerosis
□ * Spinal Cord Injury Where/ Date: ________________________
□ Depression/mental illness
□ * Kidney Problems____________________________________
□ Thyroid Problems
□ Stomach Problems____________________________________
□ *Parkinson's disease
□ * Lung Problems
□ Asthma □ COPD □ Emphysema
□ Recent Pneumonia □ Other: __________________
□ * Do you require the use of supplemental oxygen: □ Yes □ No
□ * Epilepsy/Seizures__________________________________
□ Other ____

33. Do you have any difficulty processing and/or responding correctly to situations? □ Yes □ No
If yes, give example(s) ____________________

ONLY FOR POOL PATIENTS

*34. Do you have any wounds/incisions that require a bandage?
□ Yes □ No
*35. Are you fearful of water? □ Yes □ No
*36. Assistance needed in the locker room? □ Yes □ No
*37. Do you have a problem with incontinence? □ Yes □ No

Name________________________________

Mountain Valley Therapy
Medicare Function Assessment

Modified Optimal Instrument

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do
1. Lying flat	**0**	**1**	**2**	**3**	**4**
2. Rolling over	**0**	**1**	**2**	**3**	**4**
3. Moving-lying to sitting	**0**	**1**	**2**	**3**	**4**
4. Sitting	**0**	**1**	**2**	**3**	**4**
5. Squatting	**0**	**1**	**2**	**3**	**4**
6. Bending/stooping	**0**	**1**	**2**	**3**	**4**
*7. Balancing	**0**	**1**	**2**	**3**	**4**
8. Kneeling	**0**	**1**	**2**	**3**	**4**
9. Standing	**0**	**1**	**2**	**3**	**4**
10. Walking-short distance	**0**	**1**	**2**	**3**	**4**
11. Walking -long distance	**0**	**1**	**2**	**3**	**4**
12. Walking-outdoors	**0**	**1**	**2**	**3**	**4**
13. Climbing stairs	**0**	**1**	**2**	**3**	**4**
14. Hopping	**0**	**1**	**2**	**3**	**4**
15. Jumping	**0**	**1**	**2**	**3**	**4**
16. Running	**0**	**1**	**2**	**3**	**4**
17. Pushing	**0**	**1**	**2**	**3**	**4**
18. Pulling	**0**	**1**	**2**	**3**	**4**
19. Reaching	**0**	**1**	**2**	**3**	**4**
20. Grasping	**0**	**1**	**2**	**3**	**4**
21. Lifting	**0**	**1**	**2**	**3**	**4**
22. Carrying	**0**	**1**	**2**	**3**	**4**

OFFICE USE ONLY

Body Positions (1-9) ____/36, ____%

Mobility (7, 10-16) ____/32,____%

Handling Objects (17-22) ____/24, ____%

***Continue**

*** DC**

GOAL MODIFIER________

	Current	Goal	DC	CH	0
Mobility	G8978	G8979	G8980	CI	1-20
Body Positions	G8981	G8982	G8983	CJ	20-40
Handling Objects	G8984	G8985	G8986	CK	40-60
Self-Care	G8987	G8988	G8989	CL	60-80
Other PT/OT Primary	G8990	G8991	G8992	CM	80-100
Other PT /OT Subsequent	G8993	G8994	G8995	CN	100

Mountain Valley Therapy
Falls Efficacy Scale

Name: ______________________________ Date: ______________

Please mark the most appropriate statement.

In the past 12 months . . . .

_________ a. I have fallen 2 or more times. (Please **complete** section 2)

_________ b. I have fallen 1 time and was injured (Please **complete** section 2)

_________ c. I have fallen 1 time and was not injured. (You may skip section 2)

_________ d. I have not fallen in the past 12 months. (You may skip section 2)

Section 2

On a scale from 1 to 10, 1 being extremely confident and 10 having no confidence at all, how confident are you at .....

Question	Circle best answer Most confident → Least confident									
Take a bath or shower?	1	2	3	4	5	6	7	8	9	10
Reach into cabinets or closets	1	2	3	4	5	6	7	8	9	10
Walk around the house	1	2	3	4	5	6	7	8	9	10
Prepare meals not requiring carrying heavy or hot objects	1	2	3	4	5	6	7	8	9	10
Get in and out of bed	1	2	3	4	5	6	7	8	9	10
Answer the door or telephone	1	2	3	4	5	6	7	8	9	10
Get in and out of a chair	1	2	3	4	5	6	7	8	9	10
Getting dressed and undressed	1	2	3	4	5	6	7	8	9	10
Personal grooming (I,e, washing your face)	1	2	3	4	5	6	7	8	9	10
Getting on and off of the toilet	1	2	3	4	5	6	7	8	9	10

Office Use Only

Over 65	**Fall Risk**	**Blood Pressure**
Yes No	a,b / Yes c,d / No	Sys _________ Dia __________