PATIENT QUESTIONNAIRE / HEALTH HISTORY

NAME: _____ DATE: _____

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following forms. IF you are a RETURNING patient please fill this paperwork out as if you are a 1st time patient. If you do not understand a question your therapist or an aide will assist you. Thank you.

HISTORY OF PRESENT CONDITION

PLEASE ANSWER ALL QUESTIONS TO THE BEST YOUR ABILITY EVEN IF YOU DO NOT THINK THEY APPLY TO YOUR CASE.

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

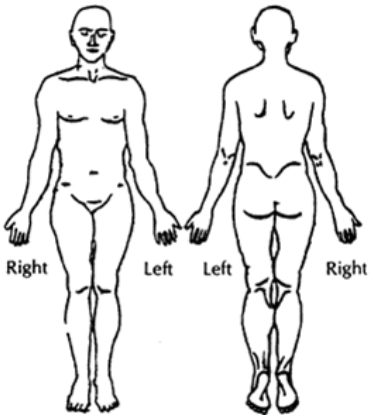
2. Check **ALL** that apply in regards to the onset of this episode?
□ Chronic
□ Gradual
□ New injury
□ Surgery for this incident
Date(s) of _____
□ Hospitalized for this incident
Date(s) of _____

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



(Shade in where appropriate)
X= pain
//= numbness/tingling
O= ache

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)_____
If yes, was it a positive experience? □ Yes □ No
If no, what was your concern or complaint?
_____
_____

11. What are you hoping to achieve/accomplish with Physical Therapy? (What have your symptoms prevented you from doing that you want to do again, i.e: walking, go back to work, holding your kids, dance, etc.)
_____
_____
_____

ASSISTED DEVICES/RESTRICTIONS

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

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

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

*15. Do you have any restrictions on weight bearing while walking?
□ Yes □ No
If so, type of brace? _____

WORK HISTORY

16a. Name of Occupation_____

16b. Employment Status (Check ALL that apply):

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

17a. Level of work-load (Check the ONE that best applies)

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

17b. 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

18. Date since last able to work: _____
19. Date at which you plan to return to work: _____
20. Are you visiting us as part of Worker's Compensation?
□ Yes □ No
21. Is there any litigation pending? □ Yes □ No

MEDICATIONS

22. 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_____

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

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

Test Results: _____
_____

PAST MEDICAL HISTORY

24. 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 (Tobacco user) _____

ONLY FOR POOL PATIENTS

*24. Do you have any wounds/incisions that require a bandage?
□ Yes □ No
*25. Are you fearful of water? □ Yes □ No
*26. Assist needed in the locker room? □ Yes □ No
*27. Do you have a problem with incontinence? □ Yes □ No

PATIENT REGISTRATION

Physical & Occupational
Mountain Valley Therapy

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

Mailing Address: _____
Street City State Zip Code

Home Phone: _____ Work : _____ Cell: _____

SS # _____ Birthdate: _____ Age: _____ Sex: Female ___ Male ___

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 any time, 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 **$75** 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 _____ Yes or No

___ Work _____ Yes or No

___ Cell _____ Yes or No

Are you interested in receiving text reminders? Yes or No

*Please note text reminders are automatically sent 24 hours prior to scheduled appointments. The text message option does not allow reply messaging/scheduling changes via text message.

Emergency Contacts

Please list at least two people who can be contacted in case of an emergency.

Name _____ Phone #_____ Location _____ Relationship_____

Name _____ Phone #_____ Location _____ Relationship_____

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)