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)

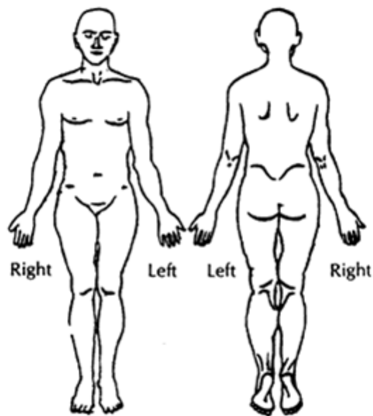
2. Check **ALL** that apply in regards to the onset of this episode?
- □ Chronic
- □ Gradual
- □ New injury
- □ Surgery for this incident
  Date(s) of __________________
- □ Hospitalized for this incident
  Date(s) of __________________

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
- □ Sharp
- □ Dull/achy
- □ Throbbing
- □ Other ____
- □ Shooting
- □ Numbness/tingling
- □ Constant
- □ Intermittent
- □ Worse in morning
- □ Worse in afternoon
- □ Worse at night

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

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

What is the most difficult part of your day? ____________________
____

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.) What are unable to do with your family?
____
____
____

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
- □ Standard walker
- □ Rolling Walker
- □ Wheelchair
- □ Cane
- □ Four-point (quad) cane
- □ Side walker (hemi-walker)
- □ 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

TESTING/IMAGING

22. 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: ____
____

ONLY FOR POOL PATIENTS

*23. Do you have any wounds/incisions that require a bandage?
□ Yes □ No

*24. Are you fearful of water? □ Yes □ No

*25. Assist needed in the locker room? □ Yes □ No

*26. Do you have a problem with incontinence? □ Yes □ No

OFFICE USE ONLY:

Height___________________ Weight______________________

□ Unable to obtain H/W, explain ________________________________

PAST MEDICAL HISTORY

27. 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: □ Yes □ No
□ Other (Tobacco user) _________________________________

Patient Name: ______________________ **Date:** ____________________

Medications: Please include all prescriptions, over the counter, and vitamins/supplements

☐ **See attached List**

Name	Dosage	Frequency	Administered Route
Example: Tylenol	500mg	4-6 hours as needed	Oral

****Do you have any emergency medication?** (Nitroglycerin, inhaler) ☐Yes ☐No

If so, please list below

Name	Dosage	Frequency	Administered Route

PATIENT REGISTRATION

2519 Cove Avenue
La Grande, Oregon 97850
Phone: 541-962-0830 Fax 541-975-2720

Name: ______________________________ Date: ______________
Last First MI

Mailing Address: ______________________________
Street City State Zip Code

Home Phone: ______________ Work : ______________ Cell: ______________

Birthdate: ______________ Age: ______ (under 18? / parent/guardian to sign paperwork) Sex: Female ___ Male ___

SS # ______________ Email Address: ______________

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

Name: ______________ Relationship: ______________
Address: ______________

What area of the body are we treating?______________
Referring Physician: ______________ Phone #: ______________

Have you had physical or occupational therapy in the last 12 months? No Yes Where? ______________
Have you had chiropractic or massage services in the last 12 months? No Yes Where? ______________
Have you ever been or are you currently enrolled in **Home Health** or **Hospice**? No Yes When? ______________

Primary Insurance: ______________ ID# ______________ Group # ______________
Subscriber Name: ______________
Subscriber Birthdate: ______________ Relationship to Subscriber: Self _____ Spouse ____ Child _____
Secondary Insurance: ______________ ID# ______________ Group # ______________
Subscriber Name: ______________
Subscriber Birthdate: ______________ Relationship to Subscriber: Self _____ Spouse ____ Child _____

If this injury is related to **Workers Compensation** OR an **Auto Accident** please fill out the following:
Insurance Company: ______________
Date of Injury: ______________ Claim #: ______________
Adjuster: ______________ Phone#: ______________

Consent to Treatment / Billing 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 for any services furnished me. 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:** ______________

FINANCIAL POLICIES

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

Patient Name: ______________________________ **Date:**____________________

*****Please initial each of the following polices to acknowledge that you read them*****

______________ (initials) **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) **Worker's Comp / 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) **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) **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) **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.

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:**________________________

Appointment Reminder Calls

Please provide the phone number you wish to be used for appointment reminder calls or text messages:

( )________ - ____________________ Is it okay to leave a message? YES____ or NO____

Are you interested in receiving text reminders? YES ____ or NO ____

*Text reminders are auto-generated 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_____________

Authorization to Disclose Information to Family Members/Others

If you wish to allow family members or others such as a spouse, significant other, or caregiver to call and request scheduling, medical or financial information from us, you must list them below and sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Mountain Valley Therapy to release any information requested to the following individuals.

1. ____ Relation to Patient: _________________________
   Circle approved information: scheduling medical financial

2. ____ Relation to Patient: _________________________
   Circle approved information: scheduling medical financial

Patient Signature: __________________________________ Date: _____________________

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)

NO SHOW/ CANCELLATION POLICY

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to our one-on-one 60-minute treatments, missed appointments are a significant inconvenience to your physical therapy, the clinic and other patients.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $75 office visit charge. This charge cannot be billed to insurance.

2. We reserve your one-hour appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to place another patient in your cancelled appointment slot to receive needed treatment.

3. Certain accident claims adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

4. After missing three appointments without notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advanced.

Thank you for providing our office and our patients with this courtesy.
Signing below indicates you understand and agree to the terms of this policy

____ __________________
Signature of Patient Date

____ __________________
Signature of Responsible Party (*if applicable*) Date

**YOU WILL RECEIVE A COPY OF THIS IN YOUR BLUE FOLDER