4121 Pennsylvania Avenue
Dubuque, IA 52002
Phone: 563.583.4003 Fax: 563.265.5789

PATIENT HEALTH HISTORY INFORMATION -PLEASE PRINT CLEARLY

Please provide a copy of your insurance card(s) to our Front Desk Staff.

Name (Last) ______________________________ (First) ________________________ (M.I) _____

Nickname __________________________ **Birth Date**_______________ **Sex:** M / F

Race: (*please circle one*) American Indian or Alaska, Asian, African American or Black, Native Hawaiian or Other Pacific Island, White, or Other race. **Language:** English Other_____________

Home Address ____**Apt/Unit**_________
City ____**State**_______ **Zip**___________
School______________________ **Teacher and Grade** _____________________________________
Student Status: Full-time / Part-time / Not Applicable

Patient Employment (if applicable): Full-time / Part-time / Not working / Retired
Employer/Occupation: __________________________ **Address:** _________________________

HOW DID YOU HEAR ABOUT US? ____

CONTACT INFORMATION:

Primary Care Physician___________________________ **Phone**_______________
Address/Facility_________________________________

A. **Responsible Party Name:** ________________**Social Security Number:** ______-_____-________
(If answer to A is self, please skip section B and continue)

B. **Mother's Name**________________________________ **Cell Phone**_________________________
Address (if different than above) ____
Home Phone________________________
Place of Employment_________________________**Work Phone**___________________________
Email____

Father's Name________________________________ **Cell Phone**_________________________
Address (if different than above)____
Home Phone________________________
Place of Employment__________________________**Work Phone**__________________________
Email____

Preferred primary contact: ____
Preferred method of contact: (*please circle one*): Home / Cell / Work **May we leave a message? YES NO**

When possible, would you like to receive text or email reminders regarding your appointments times: **YES NO**

If yes, who is your cellphone carrier: ____

Emergency Contact:

Name____**Relation**____

Address____ **Phone**________________________________

C. Does the patient receive services from any community/ home health agencies? **Yes** **No**
If answer to C is yes please list agency, supervisor and phone number.
____

D. Please list concerns necessitating therapy services____
____

EMS CONSENT:

Please specify below by checking ONE box only:

I request Unified Therapy Services to:

- ☐ PROVIDE (RESUSCITATE REQUESTED) rescue breathing or CPR if I am in their care during a time of crisis
- ☐ DECLINE (DO NOT RESUSCITATE) or use rescue breathing or CPR if I am in their care during a time of crisis.

Unified Therapy Services' policy is that a parent/guardian/caregiver is to provide a written seizure protocol detailing specific instructions for staff to follow in the event of a seizure.

☐ **I acknowledge that patient has a history of seizure activity.** When having a seizure (what occurs?)
____
____

If a seizure occurs while receiving skilled services, I would like UTS Staff to: (please print)
____
____
____

In the event of a seizure, please call:

Primary Contact: ____________________________ **Primary Phone:** _____________________

Secondary Contact: __________________________ **Secondary Phone:** ____________________

GENERAL HISTORY

A. **Allergies**: Please list any medications you are allergic to:
____

Any other allergies? ______________________________ **Are you latex sensitive**? **Yes** **No**

B. Is the patient on a special diet or do you consider him/her to be a selective eater? (if yes describe)
____

C. Has the patient ever received therapy services in the past? (If yes describe)
____
____

D. Does the patient currently utilize any adaptive equipment to assist with completion of daily activities? (If yes describe)____

E. Does the patient have equipment needs that are currently not met? (wheelchair, braces, etc) **Yes** **No** _________

F. What durable medical equipment provider or orthotics/prosthetics company does the patient currently use?
____

(If patient may need these services, we recommend you check with your insurance company to determine which medical equipment vendor your insurance will cover.)

G. Please list any pertinent medical, personal, or social information that you feel may contribute to the evaluation or treatment process____

H. If there was an injury or illness that caused a change in functioning level of the patient please describe including date of onset and change in skill level.

I. If difficulties were identified at birth please indicate complications and outcomes.

MEDICATIONS:

Please list any medication currently being taken, the dosage, frequency, and intended usage and side effects.

MEDICATION	DOSAGE	FREQUENCY	REASON	SIDE EFFECTS

Patient Diagnosis (please include all) ____

J. Please address all that apply:

Does patient have or has had difficulty with	**YES**	**NO**	**If yes, please explain including dates if pertinent**
Rolling			
Sitting			
Crawling			
Standing			
Walking			
Running			
Lower extremity weakness			
Lower extremity tightness			
One-sided weakness			
Loss of balance			
Decreased coordination			
Safety awareness			
Household chores			
Cooking			
Writing			
Bathing			
Toileting			
Dressing/Grooming			
Feeding self			
Upper extremity weakness			
Upper extremity tightness			
Fine motor coordination			
Focusing on activities			

Does patient have or has had difficulty with	**Yes**	**No**	**If yes, please explain including dates if pertinent**
Dealing with noise, touch and/or movement			
Coping skills			
Problem solving			
Following directions			
Facial weakness			
Facial tightness			
Chewing/Swallowing			
Drinking			
Articulation (speaking)			
Formulating sentences			
Addressing questions			
Memory			
Daily cognitive tasks			
Fluency			
Vocal trauma			
Hearing			
Vision			
Broken bones/fractures			
Sprains/strains			
Surgeries			
Diabetes			
Cancer			
Heart condition/ Pacemaker			
High blood pressure			
XRay, MRI, other tests			
Other			

INFORMATION RELEASE

I hereby give **Unified Therapy Services** permission to **receive and release all information** to/from the following individuals/groups/agencies/organizations regarding this patient.

(**Please check all that apply**)

- ☐ Physician______________________________
- ☐ School______________________________
- ☐ Keystone AEA______________________________
- ☐ University of Iowa Hospitals & Clinics______________________________
- ☐ Community Services______________________________
- ☐ Department of Human Services DHS______________________________
- ☐ Dubuque County Case management______________________________
- ☐ Medical Vendors______________________________
- ☐ Parents as Teachers______________________________
- ☐ Other______________________________
- ☐ Other______________________________

In the event that this patient cannot be picked up by a parent/guardian:

I hereby **authorize** to have ____________________________(name of patient) released to the following individuals:
Name _____________________________Contact Number _____________________Relationship_____________
Name _____________________________Contact Number _____________________Relationship_____________

PUBLIC RELEASE
Occasionally, Unified Therapy Services will photograph or videotape for educational and/or marketing purposes. We will always verbally discuss with the patient/parents/guardians before anything is printed for marketing purposes.

- ☐ I hereby give my permission to **ALLOW** photos/videos to be taken.
- ☐ I **DECLINE** the use of photos/videos to be taken.

*I hereby **give my permission** to use _________________________’s first name and last initial to be used by **Unified Therapy Services** to identify accomplishments, birthdays, artwork, etc.

OUTDOOR THERAPY (*please check one box below*)

- ☐ I hereby give my permission to **ALLOW** outdoor therapy. Therapy services outdoors with full knowledge that he/she may be in the public’s eye and could result in grass/dirt stains on clothing.
- ☐ I **DECLINE** the use of outdoor therapy.

HOLIDAYS
Please list any holidays in which you **DO NOT** recognize (otherwise leave blank):______________________________

BILLING/FINANCIAL

PRIMARY INSURANCE________________________________ PHONE NUMBER _____________________
INSURED’S NAME _____________________________________ INSURED’S DOB _____________________
POLICY#____ GROUP#______________________________
DRIVER’S LICENSE #___________________________________

SECONDARY INSURANCE_____________________________ PHONE NUMBER _____________________
INSURED’S NAME ______________________________________ INSURED’S DOB _______________________
POLICY#____ GROUP#_______________________________

If your child has IA Medicaid are you aware what type of waiver (if any) they are on? __________________
Please let our Billing Staff know if you have a Tertiary Insurance.

CONSENT FOR CARE/ASSIGNMENT OF BENEFITS

I certify that the above noted insurance carriers or payment sources are complete and correct as written.

I authorize Unified Therapy Services to release information from my medical records as may be necessary for the completion of the clinic’s claims for reimbursement to third party payers as needed for this or related claims. This authorization may include copies of my medical records to be sent to my insurance carrier.

In consideration of the services received or to be received by Unified Therapy services, I assign all insurance, Medicare, or Medicaid due me to Unified Therapy Services. I hereby agree to pay Unified Therapy Services any and all charges that exceed or that are not covered by my insurance coverage.

I APPROVE OF THE NOTED DIAGNOSTIC/REHABILITATIVE SERVICES.

Patient Signature____ **Date**___________________

Parent/Guardian Signature____ **Date**___________________
(If patient is a minor)