Adult Physical Therapy & Workforce Solutions

4135 Pennsylvania Avenue • Dubuque, IA 52002 • Ph 563-583-3408 • Fax 563-265-5789

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

Name (Last) ____________________________________ (First) _______________________________ (M.I) ______

Nickname ________________________________ **Birth Date**__________________ Age ______ **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**___________

Email Address______________________________________

Home Phone (____) _________________ Cell Phone (____) ______________Work Phone (____) ________________

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

Emergency Contact:
Name____Relation______________________________
Address_______________________________________ Phone________________________________

Employment Full-time / Part-time / Not Working / Retired **Employer/Occupation** __________________________
Student Status Full-time / Part-time / Not Applicable **Social Security Number:**________-______-________

Complaint/Area To Be Treated____

Injury Date_____________________________ **Date First Consulted** _______________________________________

Referring Doctor____ **Date of next appt:** ________________________

If you had a work-related injury/accident, please complete the box below:

Date of Accident: ____________________________ ☐ Auto ☐ Work Related

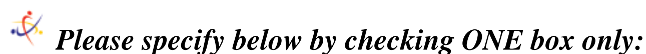
Attorney's Name, if any: _______________________________ Phone: (______) _____________________

Insurance Company: ____
Address: ____ Phone: (______) _____________________

Claim Number: ____________________________ Adjuster: __________ Name of Insured: __________________

If a work related injury Unified Therapy has my consent to share attendance, progress, and testing results with my employer. Signature ____________________________ Date ____________________

EMS CONSENT:



Please specify below by checking ONE box only:

I request Unified Therapy Health 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.

PRIMARY REASON FOR VISIT

☐ Back Pain ☐ Neck Pain ☐ Shoulder/Arm Problems ☐ Hand Problems

☐ Leg/Foot Problems ☐ Balance Problems ☐ Other

Date condition began: ___________________ Date of next doctor appointment for this condition: ______________________

Date of Surgery (if applicable): ____________________ Type of sugery: ______________________________________

SECONDARY REASON FOR VISIT (IF APPLICABLE)

☐ Back Pain ☐ Neck Pain ☐ Shoulder/Arm Problems ☐ Hand Problems

☐ Leg/Foot Problems ☐ Balance Problems ☐ Other

Date condition began: ___________________ Date of next doctor appointment for this condition: ______________________

Date of Surgery (if applicable): ____________________ Type of sugery: ______________________________________

RATE YOUR PAIN (0 IS NO PAIN, 10 IS WORST PAIN POSSIBLE)

Symptoms at worst = _____ out of 10 Symptoms at best = _____ out of 10

Have you EVER been diagnosed with any of the following conditions:

Yes	No	Angina	Yes	No	Depression	Yes	No	Joint pain
Yes	No	Anxiety	Yes	No	Diabetes Type I	Yes	No	Lymphedema
Yes	No	Arrythmia	Yes	No	Diabetes Type II	Yes	No	Migraine Headaches
Yes	No	Asthma	Yes	No	Fibromyalgia	Yes	No	MRSA
Yes	No	Blood Clotting Disorder	Yes	No	Frequent UTI	Yes	No	PVD
Yes	No	Bowel Incontinence	Yes	No	GERD	Yes	No	Multiple Sclerosis
Yes	No	Cancer	Yes	No	Glaucoma	Yes	No	MI/Heart Attack
Yes	No	Carpal Tunnel Syndrome	Yes	No	DVT	Yes	No	Osteoarthritis
Yes	No	Cellulitis	Yes	No	High Cholesterol	Yes	No	Osteoporosis
Yes	No	Chronic Back Pain	Yes	No	Gout	Yes	No	Psoriatic Arthritis
Yes	No	Chronic Neck Pain	Yes	No	Heart Disease	Yes	No	Rheumatoid Arthritis
Yes	No	Chron's Disease	Yes	No	Hepatitis B	Yes	No	Scoliosis
Yes	No	Degenerartive Disc Disease	Yes	No	Hepatitis C	Yes	No	Seizure Disorder
Yes	No	Close Head Injury	Yes	No	Hiatal Hernia	Yes	No	Shortness of Breath
Yes	No	Colitis	Yes	No	HIV/AIDS	Yes	No	Sleeping Disorder
Yes	No	Congestive Heart Failure	Yes	No	Hypertension	Yes	No	TB
Yes	No	COPD	Yes	No	Hypothyroidism	Yes	No	Do you Smoke
Yes	No	CVA (Stroke)	Yes	No	IBS			

Yes No During the Past Month have you been feeling down, depressed or hopeless?

Yes No During the Past Month have you been bothered by having little interest or pleasure in doing things?

If yes to either, is this something with which you would like help? YES NO

Yes No Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?

Yes No **FOR WOMEN**: Are you currently pregnant or do you think you might be pregnant?

Patient Name: ________________________________Patient DOB:_____________________

Do you have a pace maker, transplanted organ, joint replacement, or other metal implants? Yes   No
Explain: ____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

____

____

____

CURRENT MEDICAL CARE:

Please check any of the following whose care you have been under in the past 3 months:

☐ Physician (MD, DO)   ☐ Podiatrist (DPM)   ☐ Psychiatrist/Psychologist/Dentist
☐ Physical Therapist   ☐ Chiropractor (DC)   ☐ Other:______________________

If you have seen any of the above professionals during the last 3 months, please describe the reason (illness, medical, routine visit,etc)____

____

____

ALLERGIES:

Allergies: Please list any medications you are allergic to: ______________________________________

Any other allergies?________________________

Are you latex sensitive?   **Yes**   **No**

MEDICATIONS:

Please list any medications including pills, injections, and/or skin patches, etc you are currently taking.
(You may choose to provide a medication list to our Front Desk Staff to scan into your medical history, if easier)

____

____

Have you ever taken steroid medications for any medical conditions?   **YES**   **NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions?   **YES**   **NO**

CURRENT PROBLEM:

What date did your current problem start (roughly)? ______________________________

My symptoms are currently: ☐ Getting Better
☐ Getting worse   ☐ Staying the same

Please list any special tests performed for this problem (x-ray, MRI, labs, etc)

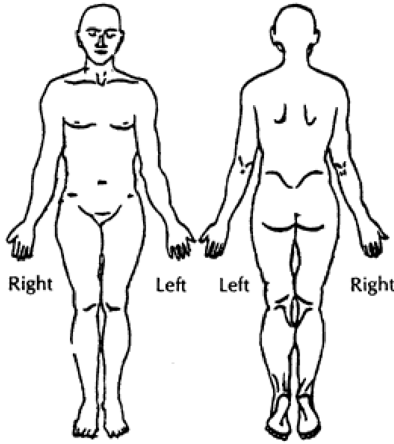
____

____

____

Patient Name: ________________________Patient DOB:________________

Body Chart



Please mark the body chart where your current symptoms are located

My symptoms currently:

- o Come and go
- o Are constant
- o Are constant, but change with activity

Using the 0 to 10 pain scale, with 0 being "no pain" and 10 being the worst pain imaginable please describe:

Circle your **current level of pain** while completing this survey: 0 1 2 3 4 5 6 7 8 9 10

Circle the **least amount of pain** you have had in the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Circle the **worst your pain** has been in the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

____

____

____

Aggravating Factors: Identify up to 3 important activities that you are unable to or having difficulty with as a result of your current symptoms:

____

____

____

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty sleeping ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms **worst**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Activity

When are your symptoms the **best?** ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Activity

By signing below, I certify that pages 1-4 of the new patient paperwork information is true and accurate to the best of my knowledge.

Patient/Guardian Signature:____Date:______________

____

Patient Name: ________________________________Patient DOB:____________________

INFORMATION RELEASE FORM:

I hereby give unified permission to receive and release all information to/from the following individuals/groups/organizations during my care at unified therapy health services.

☐ Physician____________________________________ ☐ Medical Vendors __________________________

☐ Insurance Company____________________________ ☐ Other ____________________________________

☐ School ______________________________________ ☐ Other ____________________________________

MARKETING

Please tell us how you learned of our services or whom we may thank: (circle one)

☐ I am a Previous Patient ☐ Doctor Recommendation ☐ Insurance Company Referral
☐ Website ☐ TV commercial ☐ Facebook

Family or Friend Referral________________ Newspaper Ad (please specify)___________________________

Other (please specify)__________________________________

By signing below, I certify that the previous pages of the new patient paperwork information is true and accurate to the best of my knowledge.

Patient/Guardian Signature:____Date:______________

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/Guardian Signature____ **Date**___________________

Patient Name: _______________________________Patient DOB:____________________