Adult Physical Therapy & Workforce Solutions
4135 Pennsylvania Avenue • Dubuque, IA 52002 • Ph 563-583-3408 • Fax 563-265-5789

PATIENT HEALTH HISTORY INFORMATION -PLEASE PRINT CLEARLY

Name ________________________________ **Birth Date**_____________ **Age** _______

Sex ◻ Male ◻ Female **Social Security Number** ____________________

Race ◻ American Indian or Alaska ◻Asian ◻African American or Black
◻ Native Hawaiian or Other Pacific Island ◻ White ◻Other race

Language ◻ English ◻ Other __________________________

Resides at ◻ Home ◻ Residential Care Facility _____________
◻ Intermediate Care Facility ____________________

Do you have an ID WAIVER? ◻ Yes ◻ No If yes, please see Front Desk Staff

Do you have Medicare? ◻ Yes ◻ No **If yes are you receiving home health services?** ◻ Yes ◻ No

Address ____ **Apt/Unit**__________

City ____________________________ **State** ____________ **Zip** ______________

Email Address (Correspondence and E-statements) ____________________________________

Cell Phone __________________ **Home Phone** _________________ **Work Phone** ________________

Preferred method of contact ◻ Cell ◻ Home ◻ Work **May we leave a message?** ◻ Yes ◻ No

Would you like to receive text or email appointment reminders ◻ Text ◻ Email ◻ No Thanks

Emergency Contact

Name _________________________________ Relation ________________________________

Address _______________________________ Phone _________________________________

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.

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 _____________________________________

Referring Doctor ____________________ Phone Number of Referring Doctor ______________________

Have you EVER been diagnosed with any of the following conditions:					
□ **Y** □ **N**	Angina	□ **Y** □ **N**	Depression	□ **Y** □ **N**	Joint pain
□ **Y** □ **N**	Anxiety	□ **Y** □ **N**	Diabetes Type I	□ **Y** □ **N**	Lymphedema
□ **Y** □ **N**	Arrythmia	□ **Y** □ **N**	Diabetes Type II	□ **Y** □ **N**	Migraine Headaches
□ **Y** □ **N**	Asthma	□ **Y** □ **N**	Fibromyalgia	□ **Y** □ **N**	MRSA
□ **Y** □ **N**	Blood Clotting Disorder	□ **Y** □ **N**	Frequent UTI	□ **Y** □ **N**	PVD
□ **Y** □ **N**	Bowel Incontinence	□ **Y** □ **N**	GERD	□ **Y** □ **N**	Multiple Sclerosis
□ **Y** □ **N**	Cancer	□ **Y** □ **N**	Glaucoma	□ **Y** □ **N**	MI/Heart Attack
□ **Y** □ **N**	Carpal Tunnel Syndrome	□ **Y** □ **N**	DVT	□ **Y** □ **N**	Osteoarthritis
□ **Y** □ **N**	Cellulitis	□ **Y** □ **N**	High Cholesterol	□ **Y** □ **N**	Osteoporosis
□ **Y** □ **N**	Chronic Back Pain	□ **Y** □ **N**	Gout	□ **Y** □ **N**	Psoriatic Arthritis
□ **Y** □ **N**	Chronic Neck Pain	□ **Y** □ **N**	Heart Disease	□ **Y** □ **N**	Rheumatoid Arthritis
□ **Y** □ **N**	Chrone's Disease	□ **Y** □ **N**	Hepatitis B	□ **Y** □ **N**	Scoliosis
□ **Y** □ **N**	Degenerartive Disc Disease	□ **Y** □ **N**	Hepatitis C	□ **Y** □ **N**	Seizure Disorder
□ **Y** □ **N**	Close Head Injury	□ **Y** □ **N**	Hiatal Hernia	□ **Y** □ **N**	Shortness of Breath
□ **Y** □ **N**	Colitis	□ **Y** □ **N**	HIV/AIDS	□ **Y** □ **N**	Sleeping Disorder
□ **Y** □ **N**	Congestive Heart Failure	□ **Y** □ **N**	Hypertension	□ **Y** □ **N**	TB
□ **Y** □ **N**	COPD	□ **Y** □ **N**	Hypothyroidism	□ **Y** □ **N**	Do you Smoke
□ **Y** □ **N**	CVA (Stroke)	□ **Y** □ **N**	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?

□ **Yes** □ **No** If yes to either, is this something with which you would like more resources from UTHS?

□ **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?

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:

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

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

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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.

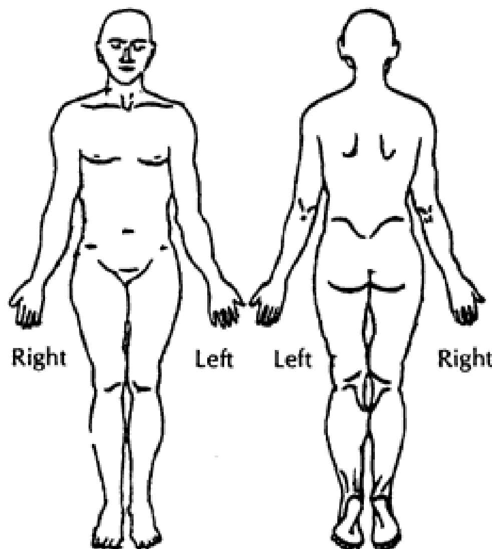
(You may choose to provide a medication list to our Front Desk Staff to scan into your medical history, if easier)

Have you ever taken steroid medications for any medical conditions? □ **YES** □ **NO**

If Yes, please explain ____

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

Body Chart



Please mark the body chart where your current symptoms are located

My symptoms currently:

- ○ Come and go
- ○ Are constant
- ○ 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:

Choose your **current level of pain** while completing this survey:

Choose the **least amount of pain** you have had in the past 24 hours:

Choose the **worst your pain** has been in the past 24 hours:

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

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BILLING/FINANCIAL

Please provide the front desk staff with all insurance cards.

INFORMATION RELEASE FORM:

I hereby give Unified Therapy Services permission to receive and release all information to/from the following individuals/groups/organizations during my care at Unified Therapy Services.

☐ Physician ______________________________ ☐ Medical Vendors ______________________

☐ Insurance Company ______________________ ☐ Other ______________________________

☐ School ________________________________ ☐ Other ______________________________

MARKETING

Please tell us how you learned of our services or whom we may thank: ________________________________

Upon discharge, may we send follow up postcards to your mailing address?: □ **Yes** □ **No**

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 **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.

UNIFIED THERAPY SERVICES ADULT PATIENT ATTENDANCE POLICY

I understand that it is my responsibility to attend all scheduled therapy appointments or to *call and cancel at least 2 hours in advance.* I further understand that messages may be left on the answering machine after hours and the staff of Unified Therapy Health Services (UTHS) will receive these messages the next business day.

- I understand that if I don't attend the scheduled appointments and do not notify UTHS prior to appointment start time, this will be considered a No Call/No Show (NC/NS) visit.
- I understand that I may be discharged from all therapy services if I have a combination of 3 NC/NS visits and/or cancellations in a row or a combination of 5 NC/NS and cancellations in a month.
- I understand that if this visit is a Telehealth session, I will be charged a $5 fee for a **No Call/ No Show** visit.
- I understand that I may be discharged from aqua therapy if I have a combination of 2 NC/NS or cancellations.
- I understand that after 2 attempts by UTHS staff to schedule I may be discharged from all therapy services.
- I understand there may be extended excused absences related to hospitalizations, surgery, injuries, illness, and extended vacations.
- I understand my employer will receive attendance reports if payment for therapy is via worker's compensation.
- I understand that if tardiness is in excess of five minutes, the staff will discuss the importance of timeliness and offer accommodation/schedule change.
- I understand I may be discharged if tardiness continues after addressed.
- I understand that transportation information is available.
- I understand any exclusion will be at the discretion of Unified Therapy Health Services.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow –up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

CONSENT FOR CARE/ASSIGNMENT OF BENEFITS/LIABILITY WAIVER

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 willingly agree to comply with the stated and customary terms and conditions for participation in therapy services and other clinic operations including protection against and possible exposure to/illness from infectious diseases and I knowingly and freely assume all such risks.

I, for myself, assigns, personal representative and next of kin, hereby release, defend and hold harmless Unified Therapy Services and their employees used to conduct therapy services and clinic operations ("releases"), with respect to any and all illness, disability, death, or loss or damage to person or property arising out of participation in therapy services or clinic operations, whether arising from the negligence of releases or otherwise, to the fullest extent permitted by law.

I APPROVE OF THE NOTED DIAGNOSTIC/REHABILITATIVE SERVICES.

Authorized Signature____ **Date**____________________

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