New Patient Orientation/Agreement

Welcome to PRN/Valley Physical Therapy

Our staff is dedicated in providing the best possible quality care in accordance with your treating doctor's orders. In order for your recovery to be the most effective, we ask that you also follow a few guidelines. Please take a minute to agree with the following guidelines.

_____ I will notify my therapist of any change or reaction with pain or discomfort (good or bad) during my treatment.

_____ I will follow my therapist' recommendations and avoid any physical activity that may contradict my treatment.

_____ I will follow my HEP (Home Exercise Program) that may be given to me by my therapist.

_____ I will notify my therapist in advance of my next doctor's appointment.

_____ I will be responsible in scheduling all of my therapy appointments and attend to them **on time** and that my appointment may be rescheduled if I am late.

_____ I will call 24 hours in advance to cancel or reschedule any appointments. I am also aware that I may be billed $25 for any appointment that I miss without calling, and that this fee will not be covered by insurance.

_____ I will be responsible to pay any co-pays/deductibles at the time of my visit.

I have read, understood, and agreed to all of the above:

______________________________ ______________________

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, Valley Physical Therapy Group creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices which provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that the Notice of Privacy Practices may change at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand for **Worker's Compensation Cases**, the minimum necessary PHI/ePHI will be released to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Valley Physical Therapy Group is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_______] Spouse/Children:____

[_______] Other: ____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:

[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide email address or phone number: ____

I acknowledge that I have received a copy of the Notice of Privacy Practices and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

______________________________ ______________ ____________________

Signature of patient or legal representative Date Relationship to Patient

____

Printed name of patient

VALLEY PHYSICAL THERAPY GROUP

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name: ______________________________ Today's Date: _______________

Email Address: ___________________________

DOB: __________ Age: ____ Height: _____ Weight: _____ Do you smoke? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female

If female, are you currently pregnant? ☐ Yes ☐ No If yes, ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Heart Condition	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No				

Other: ____

Who referred you to physical therapy? ____

Primary Physician: ____

<u>Tell us about your condition</u>

When did you first notice the pain or have functional problems due to the condition/injury?

(Please provide approximate dates): ____

Recent flare-up? ☐ Yes ☐ No If yes, when ____

What activities are limited by this condition? (i.e. lift, reach): ____

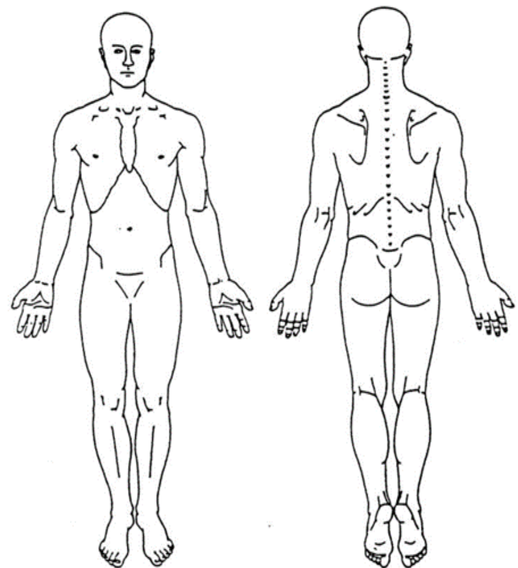
How did your injury/symptoms occur? ____

____

What do you expect to accomplish with physical therapy? ______________________________________

Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ Getting Better?
☐ Getting Worse? ☐ Staying the same?

Indicate on body diagrams where your symptoms are located.



What makes your symptoms better? ______________________________

0-10 pain scale (0 = no pain; 5 = moderate pain; 10 = the most extreme pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

☐ Surgery: When? __/__/__ What kind? ____________________________

☐ Injection: When? __/__/__ Did it help? ☐ Yes ☐ No

☐ Other treatment:

☐ Physical therapy If yes, when? __/__/__to__/__/__
What was done? ____

☐ Chiropractor If yes, when? __/__/__to__/__/__
What was done? ____

☐ Medications: ____

☐ X-ray __________________ ☐ MRI ____________________

☐ CT Scan _________________ ☐ Other: ___________________

☐ Exercises: What kind? _________________________________

Comments: ____

____

____

Work Information

Who is your employer? ____

What is your job title/responsibilities? ____

Are you currently working? ☐ Yes ☐ No If yes, number of hours per week ______________________

☐ Full Duty ☐ Restricted Duty

How many total work days have you missed? ______ Do you have a case manager/QRC? ☐ Yes ☐ No

Indicate either "Yes" or "No" as to whether each of the following activities is difficult.

Drinking or eating	☐ Yes ☐ No		Balancing on both feet	☐ Yes ☐ No
Sleeping through the night	☐ Yes ☐ No		Walking on: stairs, flat surfaces, inclines, uneven surfaces, or ladders	☐ Yes ☐ No
Dressing: putting on or taking off shoes, socks, shirt, jacket, or pants	☐ Yes ☐ No		Lifting	☐ Yes ☐ No
Maintaining static position of: head bent forward, arms overhead, arms forward, or turning head	☐ Yes ☐ No		Carrying	☐ Yes ☐ No
Getting in/out of chairs, bed, car, or bath/shower	☐ Yes ☐ No		Bending, kneeling, or squatting	☐ Yes ☐ No
Reaching: overhead, behind back, downward, or forward	☐ Yes ☐ No		Driving a vehicle or ability to use gas/brake pedals	☐ Yes ☐ No
Gripping, holding tools, or opening jars	☐ Yes ☐ No		Caring for child or adult	☐ Yes ☐ No
Picking up small objects	☐ Yes ☐ No		Housework/yardwork	☐ Yes ☐ No
Sitting	☐ Yes ☐ No		Recreational activities	☐ Yes ☐ No
Standing	☐ Yes ☐ No		Have you fallen more than 1 time in the past year	☐ Yes ☐ No
Job related activities	☐ Yes ☐ No		Have you fallen and hurt yourself in the past year	☐ Yes ☐ No

Other:

Your therapist will complete this section

Critical work, ADL, or leisure activities affected: ______________________________________

- Lift/carry: ☐ < 20 lbs. rarely to occasionally (low demand)
  ☐ > 20 lbs., or > 1 lb. constantly or > 10 lb. frequently (mod-high demand)
  Where to where: __________________to__________________
- Repetitive motions related to condition: ☐ Occasional 1-33% (low demand)
  ☐ Frequent to Constant 34-100% (mod-high demand)
- Static positions related to condition (mod-high): ☐ Sit ☐ Stand ☐ Crouch
  ☐ Kneel ☐ Overhead work ☐ Other ____________
- Leisure activities: ☐ None/minimally impact condition (low demand)
  ☐ Moderate-high intensity, competitive (mod-high demand)

Overall functional demand (work/ADL/leisure) ☐ Low demand ☐ Moderate-High Demand

Comments: ____

Additional comments: ____

VALLEY PHYSICAL THERAPY GROUP
CURRENT LIST OF MEDICATIONS REPORT

Patient Name: **Date:**

LIST ALL THE PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING			
NAME OF MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)

LIST ALL OVER-THE-COUNTER MEDICATIONS			
NAME OF MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)

LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS			
NAME OF MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)