Date: _____ Name: _____

DOB: _____ Acct: _____

Patient Health History and Information

Age: _____ **Height:** _____ **Weight:**_____ **Sex:** M F **Dominant hand:** R L **Could you be or are you pregnant:** Yes No

Occupation/job title: _____ Self Student Full time Part time Retired Unemployed

Reason for Therapy:_____

Date of injury or onset of symptoms: ___/___/___

Please describe how your injury/problem occurred:_____

Please list any treatment you have received for this condition(ie. PT, chiro)_____

Injection: type: _____ ___/___/___ Surgery: type:_____ ___/___/___ Other:_____ ___/___/___

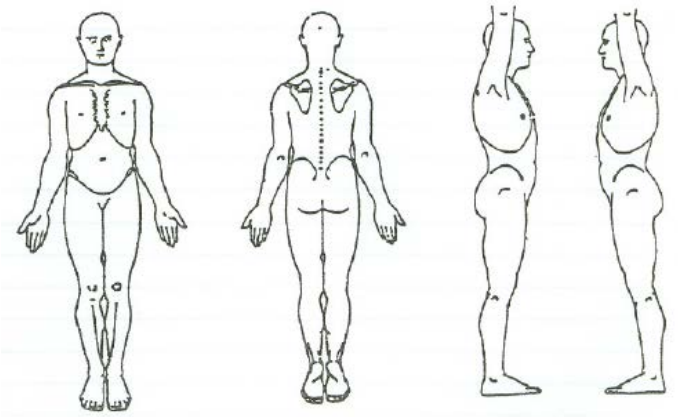
For this condition have you had any of the following? EMG___/___/___ X-ray ___/___/___ MRI / CT scan ___/___/___

Have you had this problem before? _____ When?_____ What kind of treatment?_____

Using the key below indicate on the body diagrams where your symptoms are located.

X=Pain **//**= Numbness

O=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Please describe CIRCLE your pain/symptoms

Constant	Intermittent	Sharp	Dull	Aching	Burning
Decreasing		Increasing		Staying the same	
Weakness	Giving way	Throbbing	Other:_____		

Which side are we seeing you for?: Right Left

What makes your symptoms worse _____

What makes your symptoms better? _____

Limitations due to your current problem:_____

____Laying down	____Bending	____Turning Head	____Sleep/Awake from Pain
____Sit to stand	____Work	____Sitting	____Self Care/Hygiene
____Up/Down Stairs	____Driving	____Walking	____Home activities
____Squatting/Lifting	____Swallowing	____Standing	____Repetitive activities
____Looking overhead	____Talk/Chew/Yawn/All	____Reaching	____Sport/Recreation
____Taking a breath	____ Cough/sneeze pain	____Child care	

What are your goals for therapy? (Two things you want to be able to do again or do better)

1._____ **2.** _____

Since your symptoms began have you had any of the following:

Fever / Chills	Yes No	Unexplained weight change	Yes No
Nausea / Vomiting	Yes No	Night sweats / pain	Yes No
Numbness genital/anal area	Yes No	Problems with vision / hearing / speech	Yes No
Dizziness / Fainting	Yes No	Difficulty with bowel/bladder function	Yes No
Unexplained weakness	Yes No	Other:_____	Yes No
Headaches	Yes No		

Date:_____ Name:_____

D.O.B._____ Patient Account _____
Insurance: _____

Who referred you to Physical Therapy? _____**Primary Physician**: _____

How did you hear about MSSR Physical Therapy? Physician Friend/relative Website Previous patient Self Coach Other

GENERAL HEALTH HISTORY:

Have you had any falls or near falls in the past year? _____ Yes ____ No

Rate your overall health: Excellent Good Average Poor

Living Situation: Alone Spouse Family Others

Do you exercise? Yes No _____x/week Type:_____

Do you smoke? Yes No **Do you drink caffeinated beverages?** Yes No ____/week

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Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other:_____

Employer:_____ **Current work duty:** Full duty Restricted duty **Work days missed:** _____

QRC and/or Adjuster (if you have one)**:**_____

Surgical history: _____

Have you or anyone in your immediate (brother, sister, parent, grandparent) **family ever been diagnosed with any of the following:**

Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Anxiety	Self	Family	No	Thyroid problems	Self	Family	No
Cancer	Self	Family	No	Epilepsy/dizziness	Self	Family	No
High Cholesterol	Self	Family	No	Tuberculosis	Self	Family	No
High blood pressure	Self	Family	No	Anemia/blood disorder	Self	Family	No
Heart trouble/angina	Self	Family	No	Multiple Sclerosis	Self	Family	No
Diabetes	Self	Family	No	Circular/vascular problems	Self	Family	No
Stroke	Self	Family	No	Chemical dependency	Self	Family	No
Osteoporosis	Self	Family	No	Pace maker/metal implants	Self	Family	No
Osteoarthritis	Self	Family	No	AIDS/HIV	Self	Family	No
Rheumatoid arthritis	Self	Family	No	Hepatitis	Self	Family	No
Depression	Self	Family	No	Bladder/bowel problems	Self	Family	No
Headaches	Self	Family	No	Other:			

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest in the pleasure of doing things: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day
2. Feeling down, depressed or hopeless: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not effect your ability to benefit from physical/occupational therapy treatment: No _____ Yes _____

Patient Signature: _____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

MD follow-up: ____/____/____ ☐ None Scheduled

With-in 90 days of last Medical history completion (date and initial any changes)
– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature:_____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

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Patient Name:	**Date of birth:**	**Date Completed:**
Allergies/Adverse effects to medications:		

1. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications.
2. Please fill out the chart below. ****If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.**

Name of <u>prescription medication</u> (brand or generic)	**Dosage**	**Why are you taking this medication?**	**How often do you take it?**	**How do you take it? (by mouth, injection, etc.)**
Example: *Lasix*	*20 mg.*	*High blood pressure*	*Two times a day*	*By mouth*

<u>Over the Counter medication</u> or <u>nutritional supplements</u>	**Dosage**	**Why are you taking this medication?**	**How often do you take it?**	**How do you take it? (by mouth, injection, etc.)**

Patient updated:	**Date:**		**Patient updated:**	**Date:**
Therapist reviewed:	**Date:**		**Therapist reviewed:**	**Date:**

MINNESOTA SPORT & SPINE REHABILITATION (An Associate of Therapy Partners, Inc.)

AUTHORIZATION TO TREAT: I voluntarily consent to therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare MSSR. I authorize MSSR to provide such treatment. **MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION. I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR THERAPYSERVICES RENDERED.** Initials _____

GUARANTEE OF PAYMENT: I understand that all balances designated as 'the patient's responsibility' such as co• insurances, co- payments and deductibles are due and payable to MSSR. I guarantee I will pay the amount deemed "my responsibility" by the insurer at the time the claims are processed, by the statement due date. As part of working with my insurance carrier, I recognize that MSSR may be provided with information about my insurance coverage, and that on occasion MSSR may share some of this information with me. However, I understand and acknowledge that MSSR is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan documents and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. This is not a guarantee of payment. Initials _____

We have contacted your insurance regarding your benefits. This information will be printed on the registration form for you to review at check in. If your deductible has not been met or you have a balance, we would be happy to receive payment for your therapy services at each visit.

INSURANCE BENEFITS ASSIGNMENT: I authorize that the payment of my insurance benefits be made directly to MSSR for all services delivered; if I am paid directly I will promptly pay MSSR all monies paid to me. Initials _____

HIPAA PRIVACY POLICY: My signature below indicates that I have been given the Notice of Privacy Practices for MSSR. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to MSSR to release any of my protected healthcare information. Initials _____

CANCEL/NO SHOW POLICY: I have read and understand MSSR Cancel/No Show Policy and know that if I would like a copyof it to keep, I can request one. Initials _____

RECORD RELEASE: I am aware that MSSR may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care. Initials _____

I would like MSSR to disclose my Protected Health Information to individuals other than those listed above. YES NO
(If YES, you must complete an Authorization to Release PHI form)

REMINDER CALLS: As a service to patients, we provide appointment reminder call and other calls (ie. Weather closure) that maybe placed using prerecorded message. By providing your number, you consent to receive such calls. Initials _____

Date:_____ **Patient's Printed Name**: _____

Signature of Patient or Patient Representative and relationship: _____
REQUIRED SIGNATURE (Update Annually)

REVIEW AND INITIAL BELOW ONLY IF APPROPRIATE

MEDICARE PATIENTS ONLY: Are you currently, or in the last 30 days have you received any type of Home Health Services, physical/speech/occupational therapy from a home health care agency, transitional care facility, or nursing home? YES NO If YES, we cannot treat you today until you have been discharged. Medicare will not pay for our services. Initials _____

SELF REFERRAL OR OUT OF STATE REFERRAL: I understand that if I have been referred by a physician who is not licensed in the state of MN and I am being treated at a clinic in MN, I will be considered a Self-Referral and can be treated for 90 days. After that time, if I would like to continue treatment, I will need to obtain an order from a physician who is licensed in the state of MN. The same 90 day rule pertains if I have not been referred by a physician and I am self-referring. Initials _____

PAYMENT AUTHORIZATION – PROMPT PAY: Your services will not be billed to your insurance company or do not qualify for coverage. Charges must be paid in full at the time of service in order to receive the prompt pay discount. The amount charged is determined by the case's complexity. Cost of the evaluation is $ _____ and follow up is $_____. If a supply or orthotic is issued, there will be an additional charge. I do not want my services billed to an insurance company, and will not do so myself. Initials _____