



Date: _____ Name: _____
 DOB: _____ Acct: _____
 Insurance: _____

Patient Health History and Information

Age: _____ Height: _____ Weight: _____ Sex: M F Pronoun: He/Him She/Her They/Them

Dominant hand: R L Could you be or are you pregnant: Yes No

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

Reason for Therapy: _____

Date of injury or onset of symptoms: ___/___/___ Surgery for this condition: Yes/ No Date ___/___/___ Type _____

Please describe how your injury/problem occurred: _____

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

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

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

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

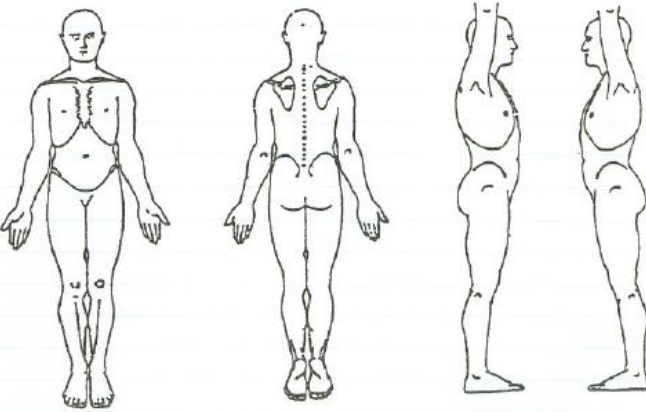
Using the key below indicate on the body diagrams where your symptoms are located.

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: _____

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Laying down | <input type="checkbox"/> Bending | <input type="checkbox"/> Turning Head | <input type="checkbox"/> Sleep/Awake from Pain |
| <input type="checkbox"/> Sit to stand | <input type="checkbox"/> Work | <input type="checkbox"/> Sitting | <input type="checkbox"/> Self Care/Hygiene |
| <input type="checkbox"/> Up/Down Stairs | <input type="checkbox"/> Driving | <input type="checkbox"/> Walking | <input type="checkbox"/> Home activities |
| <input type="checkbox"/> Squatting/Lifting | <input type="checkbox"/> Swallowing | <input type="checkbox"/> Standing | <input type="checkbox"/> Repetitive activities |
| <input type="checkbox"/> Looking overhead | <input type="checkbox"/> Talk/Chew/Yawn/All | <input type="checkbox"/> Reaching | <input type="checkbox"/> Sport/Recreation |
| <input type="checkbox"/> Taking a breath | <input type="checkbox"/> Cough/sneeze pain | <input type="checkbox"/> Child care | |

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

1. _____ 2. _____

GENERAL HEALTH HISTORY:

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

Table with 4 columns: Symptom, Yes, No, and another Yes/No column. Symptoms include Fever/Chills, Nausea/Vomiting, Numbness genital/anal area, Dizziness/Fainting, Unexplained weakness, Headaches, Unexplained weight change, Night sweats/pain, Problems with vision/hearing/speech, Difficulty with bowel/bladder function, and Other.

Have you had any falls or near falls in the past year? Yes/No. If yes, how many _____

Rate your overall health: Excellent Good Average Poor Living Situation: Alone Spouse Family Others

Do you exercise? Yes/No ___x/wk Type: ___ Do you smoke? Yes/No Do you drink caffeinated beverages? Yes/No ___/wk

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

Table with 4 columns: Condition, Self, Family, No. Conditions include Allergies/asthma, Anxiety, Cancer, High Cholesterol, High blood pressure, Heart trouble/angina, Diabetes, Stroke, Osteoporosis, Osteoarthritis, Rheumatoid arthritis, Depression, Headaches, COVID-19, Kidney problems, Thyroid problems, Epilepsy/dizziness, Tuberculosis, Anemia/blood disorder, Multiple Sclerosis, Circular/vascular problems, Chemical dependency, Pace maker/metal implants, AIDS/HIV, Hepatitis, Bladder/bowel problems, and Other.

SURGICAL HISTORY (please list any surgeries): _____

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 affect your ability to benefit from physical/occupational therapy treatment: No ___ Yes _____

WORK HISTORY:

Occupational/job title: _____ Self Student Full Time Retired Unemployed

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): _____

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.)
<i>Example: Lasix</i>	<i>20 mg.</i>	<i>High blood pressure</i>	<i>Two times a day</i>	<i>By mouth</i>

<u>Over the Counter medication or 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 (A Member Practice of Therapy Partners)

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 facility. 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 THERAPY SERVICES RENDERED.** Initials _____

PAYMENT AUTHORIZATION: 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 agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. 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 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 and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. This is not a guarantee of benefits. Initials _____

We have contacted your insurance company 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. This policy is provided in every new patient packet and I may request a new copy at any time. Initials _____

TELEHEALTH/E-VISIT APPROVAL: I approve the possibility of being seen by a clinician via telehealth for some portion of my care. Initials _____

REMINDER CALLS: As a service to patients, we provide appointment reminder calls, text messages, or emails and other calls (ie. Weather closure). By providing your number, you consent to receive such calls. 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 individual(s) not listed above. **YES NO**
(If YES, you must complete an Authorization to Release PHI form)

Date: _____ Patient's Printed Name _____

Signature of Patient or Patient Representative: _____

Patient Representatives Printed Name and Relationship if applicable: _____

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, PT/OT/ST from a home health care agency, transitional care facility, or nursing home?: YES NO **If YES**, we cannot treat you until you have been discharged. Medicare will not pay our services. You may request Medicare Cap information. 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. 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 _____