| 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:**_________________________________________________________________

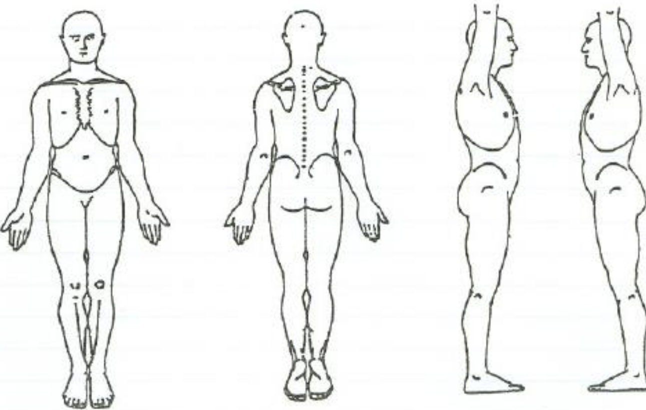
**Please list any treatment you have received for this condition( ie. PT, chiro)**_________________________________________

**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**:_____________________________________________________________

| | | | |
| --- | --- | --- | --- |
| ____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.** _______________________________________________

**GENERAL HEALTH HISTORY:**

**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 | | | |

**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:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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: ___________________________________ | | | |
| COVID-19 | Self | Family | No | | | | |

**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 ________________________________________

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**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):__________________________________________________________________

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**Patient Signature:** ________________________________________ **Date** ____/____/____

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

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

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**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* |
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| **<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.)** |
|---|---|---|---|---|
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| **Patient updated:** | **Date:** | | **Patient updated:** | **Date:** |
|---|---|---|---|---|
| **Therapist reviewed:** | **Date:** | | **Therapist reviewed:** | **Date:** |

## MINNESOTA SPORT & SPINE REHABILIATION (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 ___________

**REMINDERS:** As a service to patients, we provide appointment reminder calls, text messages, or emails and other calls (ie. Weather closure). By providing your phone number or email, you consent to receive such reminders. 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 separate 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**

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**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 for 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 ____________

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