Treasure Valley PHYSICAL THERAPY INC

Ontario 541 889 2221 fax 541 889 3437 • Payette 208 739 4453 fax 208 739 4454
www.treasurevalleypt.com

Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Phone: (Home)_____ (Cell)_____ (Work)_____

Soc Sec #: _____ Patient Sex: ❑Male ❑Female Marital Status: ❑Single ❑Married ❑Widowed

Age: _____ Height: _____ Weight: _____ E-mail Address: _____

Occupation: _____ Currently Working: ❑Yes ❑No Employer: _____

Work restrictions per MD: ❑Yes ❑No Attorney: ❑Yes ❑No Attorney Name: _____

How did you hear of us (please check all that apply):
❑MD ❑Friend/Relative ❑Community Service ❑TV/Radio ❑Phone Book ❑Web Page ❑Location ❑Prior TVPT patient ❑Insurance ❑Other

Person to contact in case of emergency:
Name: _____ Phone Number: _____ Relationship: _____

Injury/Condition Information

What problem or diagnosis brings you to Treasure Valley Physical Therapy?

_____

Date of Injury: _____ Type of Injury/Condition: ❑Auto accident ❑Work injury ❑Accident ❑Sports ❑Unknown

Did you have surgery: ❑Yes ❑No Date of surgery: _____ Type of surgery:_____

Physician: _____ Date of Physical Therapy order: _____

Prior PT, OT, and/or chiropractic care this year? ❑Yes ❑No If yes, was it for the same condition? ❑Yes ❑No

Have you been treated at Treasure Valley before? ❑Yes ❑No If yes, when (ie year)? _____

The following test(s) have been performed for this problem: ❑X-ray ❑MRI ❑CAT ❑EMG ❑None ❑Other_____

Please explain how your condition happened: _____

_____

Please describe your pain: _____

_____

Please rate your pain on a scale from 0 (no pain) – 10 (worst pain)

Your pain currently	0 1 2 3 4 5 6 7 8 9 10
The best it has been since the injury	0 1 2 3 4 5 6 7 8 9 10
The worst it has been since the injury	0 1 2 3 4 5 6 7 8 9 10

Is your pain affecting your ability to sleep? ❑Yes ❑No

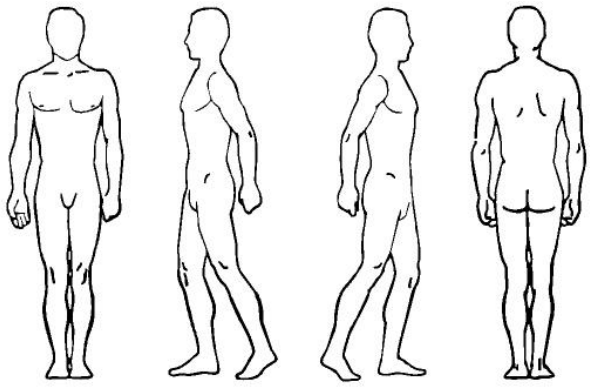
Does the time of day affect your symptoms? ❑Yes ❑No

Does coughing/sneezing increase your symptoms? ❑Yes ❑No

What makes your symptoms BETTER? _____

What makes your symptoms WORSE? _____

Please draw your painful areas on the body diagrams



What do you hope to gain from physical therapy? _____

Please continue on back…

Medical History

I CURRENTLY have, or have had a HISTORY of: (please check all that apply)

Yes	No		Yes	No		Yes	No	
❑	❑	High blood pressure	❑	❑	Currently Pregnant	❑	❑	Allergies to tape or lotions
❑	❑	Heart trouble/angina	❑	❑	Seizures	❑	❑	Sensitive to heat/ice
❑	❑	Pace maker	❑	❑	Osteoporosis	❑	❑	Severe night pain
❑	❑	Diabetic	❑	❑	Headaches	❑	❑	Major injury to neck/spine/back
❑	❑	Smoking/tobacco use	❑	❑	Dizziness	❑	❑	Hearing problems
❑	❑	Cancer/tumor	❑	❑	Asthma/shortness of breath	❑	❑	Hepatitis A,B, or C/HIV
❑	❑	Stroke	❑	❑	Kidney problems	❑	❑	Tuberculosis
❑	❑	Bowel/bladder problems	❑	❑	Nervous disorder	❑	❑	Other_____

CURRENT MEDICATION use:

Medication	Dosage	Frequency	By mouth	Medication	Dosage	Frequency	By mouth
			❑Y ❑N				❑Y ❑N
			❑Y ❑N				❑Y ❑N
			❑Y ❑N				❑Y ❑N
			❑Y ❑N				❑Y ❑N

Please list PREVIOUS SURGERIES and their dates:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

FALLS: Have you fallen in the last year? ❑yes ❑no Did you sustain an injury because of the fall? ❑yes ❑no

Patient Authorization:

PARENTAL CONSENT NEEDED IF PATIENT IS UNDER THE AGE OF 18
I hereby give my consent as a Parent/Guardian of _____for physical therapy evaluation and treatments rendered by Treasure Valley Physical Therapy, Inc. _____

CONSENT FOR TREATMENT: I, the undersigned, give consent to Treasure Valley Physical Therapy to perform physical therapy evaluation and treatment techniques as required to appropriately rehabilitate my therapy related conditioning.

FINANCIAL POLICY: Insurance coverage is an arrangement between the insurance carrier and the patient. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. **Ultimately, you and only you are responsible for understanding the specifics of your insurance plan and their benefits**. You bear full financial responsibility for the services provided by Treasure Valley Physical Therapy and agree to pay all co-payments, coinsurances, and deductibles at the time of service. Additionally, you authorize and request that insurance payments be made directly to Treasure Valley Physical Therapy. Accounts turned over to a collections agency, and all returned or cancelled checks will be assessed a $25.00 fee.

RELEASE OF INFORMATION: I authorize Treasure Valley Physical Therapy to disclose all or any part of my medical or financial records to any party who is or may be liable under any contract to myself, a family member, or any employer for all or any part of the physical therapy charges. All or any of my medical records may also be released to other health care agencies when required to provide complete care.

FOR MEDICAID PATIENTS ONLY: I understand that I am financially responsible to Treasure Valley Physical Therapy for charges not covered by this assignment including Public Medical Assistance Programs. It is my choice not to go through the formal authorization of review process for non-emergent medical services.

CANCELLATION POLICY: I understand that Treasure Valley Physical Therapy reserves the right to charge me a $25 dollar cancellation fee for each scheduled appointment that I do not attend, unless I cancel by phone 24 hours in advance.

INDIVIDUAL ACKNOWLEDGEMENT RECEIVED NOTICE OF PRIVACY PRACTICE

I, _____, acknowledge that I received TVPT's Notice of Privacy Practices.
Please Print Name

Your signature represents your consent to treatment, your acknowledgement of full financial responsibility, and your understanding and acceptance of our policies detailed above.

Patient Signature: _____ Date: _____

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