

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/week Type:_____ Do you smoke? Yes/ No Do you drink caffeinated beverages? Yes/No ___/we

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

WORK HISTORY:

Occupation/job title: _____ Self Student Full time Part 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 ____/____/____



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 FACILITY 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 FACILITY. 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 FACILITY may be provided with information about my insurance coverage, and that on occasion FACILITY may share some of this information with me. However, I understand FACILITY 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 and they reported the following information. Deductible \$_____. Co-insurance amount _____%. Co-pay amount \$_____. Visit Limit_____. 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 FACILITY for all services delivered; if I am paid directly I will promptly pay FACILITY all monies paid to me. Initials _____

HIPAA PRIVACY POLICY: My signature below indicates that I have been given the Notice of Privacy Practices for FACILITY. 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 FACILITY to release any of my protected healthcare information. Initials _____

RECORD RELEASE: I am aware that FACILITY 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 _____

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

Phone Number: _____ Phone Carrier: _____ Email: _____ Initials _____

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, therapy 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. 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 _____

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