

**RIVERVIEW PHYSICAL THERAPY PATIENT DATA SHEET**

**First:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** Male  Female

**Physical Address:** \_\_\_\_\_ **Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Phone Numbers:</b>	<b>OK To Call</b>	<b>Best Time To Call</b>
Home: _____	<input type="checkbox"/>	_____
Work: _____	<input type="checkbox"/>	_____
Cell: _____	<input type="checkbox"/>	_____

**May we send you text messages for your appointment reminders to the number(s) listed above?**  Yes  No

**May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above?**  Yes  No

**By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information**

**May we send you emails relating to your care with us?**  Yes  No  
**By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.**  
**Email:** \_\_\_\_\_

**Preferred language:** \_\_\_\_\_ **Interpreter required?**  Yes

**Date of Injury:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_  
**Injury Area:** \_\_\_\_\_ **Auto or Work Accident:**  Auto  Work  N/A

**State Where Accident Occured:** \_\_\_\_\_  
**Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days?**  Yes  No  
**Are you currently receiving or have you received other therapy services in the last 60 days?**  Yes  No

**Marital Status:**  
 Married  Single  Divorced  Widowed  Separated  Unknown

**Student Status:**  
 Full-Time  Part-Time  None

**EMPLOYMENT STATUS**

**Employment Status:**

Active Military    Full-Time    None    Part-Time    Retired    Self Employed

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**How did you hear about us?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Physician      | <input type="checkbox"/> Hospital               | <input type="checkbox"/> Marketing Ad - Print               |
| <input type="checkbox"/> Employer       | <input type="checkbox"/> Cross Referral         | <input type="checkbox"/> Marketing Ad - TV                  |
| <input type="checkbox"/> Case Manager   | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard           |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney               | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor       | <input type="checkbox"/> Self                   | <input type="checkbox"/> Marketing Ad - Facebook            |
| <input type="checkbox"/> School         | <input type="checkbox"/> Screens - Open Houses  | <input type="checkbox"/> Marketing Ad - Other _____         |

Specify if other : \_\_\_\_\_

**Note: Please provide us with the most updated information below.**

**EMERGENCY AND OTHER CONTACTS**

Name	Phone	Work	Cell	Fax	Type

**DISCLOSURE OF MEDICAL RECORDS**

I authorize the following individuals to have access to my medical and billing records:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



# Medical History Form

Patient Name:		Today's Date:	
Referring Physician:		Date of Birth:	Age:
Primary Care Physician:		Date of Injury or Onset:	
Date of Next Physician Appointment:			
Reason for Therapy:			
Cause of Injury or Onset: <input type="checkbox"/> Accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other:      If Other, please explain:			
Have you been hospitalized for the present condition? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, date:			
Did you have surgery for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, date: If Yes, surgery type:			
Are you currently receiving any other care for the condition mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:			
Have you ever received therapy in the past for the condition mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, date: Describe previous treatment:			
Previous Treatment: <input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful			
Have you fallen in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, how many times?      If Yes, were you injured? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you feel unsteady when standing or walking? <input type="checkbox"/> Yes <input type="checkbox"/> No      Do you worry about falling? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What are your personal goals/outcomes you hope to achieve from therapy?			
Describe your general health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		Do you smoke or use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)			
<input type="checkbox"/> Allergies <input type="checkbox"/> Latex <input type="checkbox"/> Other	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy or Seizure Disorder	<input type="checkbox"/> Metal Implants	
<input type="checkbox"/> Anxiety or Panic Disorders	<input type="checkbox"/> Fainting	<input type="checkbox"/> MRSA	
<input type="checkbox"/> Arthritis <input type="checkbox"/> OA <input type="checkbox"/> RA	<input type="checkbox"/> Fatigue or Weakness	<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fever or Chills	<input type="checkbox"/> Nausea / Vomiting	
<input type="checkbox"/> Use of Blood Thinners	<input type="checkbox"/> Fractures	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Bowel or Bladder Disorder	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Head Injury or Concussion	<input type="checkbox"/> Parkinson's Disease	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Peripheral Vascular Disease	
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Heart Disease or Heart Attack	<input type="checkbox"/> Respiratory or Breathing Problems	
<input type="checkbox"/> COPD	<input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Ringing in Ears	
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hernia	<input type="checkbox"/> Sexual Dysfunction	
<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> Skin Abnormalities	
<input type="checkbox"/> Deep Vein Thrombosis (DVT)	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Stroke or TIA	
<input type="checkbox"/> Depression	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Hypersensitivity to Hot or Cold	<input type="checkbox"/> Tuberculosis	
List any other medical problems and explain:			

# Medical History Form

## Medication List

Name of Medication	Dosage	Frequency	
<input type="checkbox"/> Check Box if Medication List provided separately.			
1.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
2.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
3.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
4.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
5.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
6.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
7.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
8.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
9.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
10.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
11.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
12.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
<b>Over the Counter Medications (check all that apply):</b> <input type="checkbox"/> Aspirin/Ibuprofen <input type="checkbox"/> Antacids <input type="checkbox"/> Sleeping Aids <input type="checkbox"/> Cold Medicine: <input type="checkbox"/> Cough Medicine <input type="checkbox"/> Allergy Relief <input type="checkbox"/> Laxative <input type="checkbox"/> Diet Pills <input type="checkbox"/> Vitamins/Herbal Supplements <input type="checkbox"/> Other:			

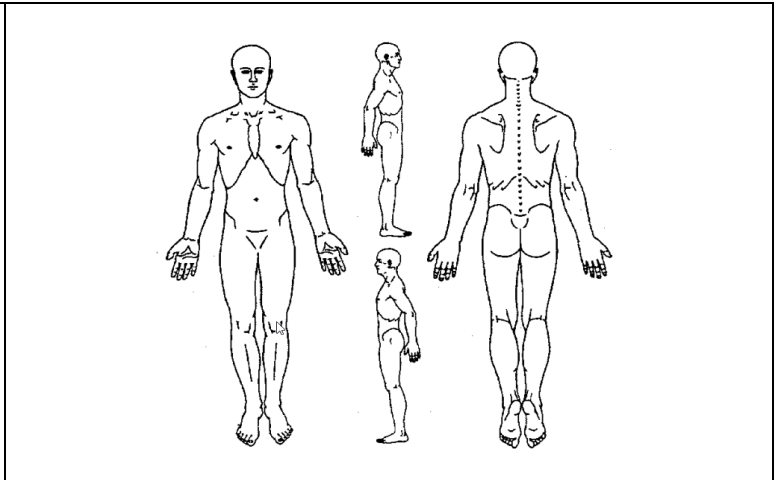
**Pain Scale**  
 Rate the severity of your pain by circling a box on the following scale.

No Pain Worst Pain

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

**On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.**

**KEY:**  
 A = Aching      B = Burning      N = Numbness  
 P = Tingling    S = Stabbing    O = Other



<b>Signature of Patient:</b>	<b>DOB:</b>
<b>Printed Name of Patient:</b>	<b>Date:</b>