

Iowa Therapy Group Patient Information

Date: _____

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Gender: Male Female Date of Birth: _____

Marital Status: Single Married Widow Divorced Status: Student Employed Retired

Mailing Address: _____ Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Was condition related to: () Employment () Auto Accident () Other _____

Date condition / Accident began: _____

Referring Physician: _____ Next Appointment: _____

Family Physician: _____

Employer: _____ Employer Phone #: _____

PRIMARY INSURED'S INFORMATION

(This is the person, if different from the patient, whose name appears on your insurance card. If more than one name appears on the insurance card, the primary or first person named on the card.)

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____ SS #: _____ Date of Birth: _____
(month/day/year)

Please provide contact information where someone can be reached in case of
EMERGENCY while patient is receiving therapy

Name: _____ Relationship: _____ Phone Number: _____

Is this an emergency contact? Y N

Is this person permitted to discuss your medical information? Y N

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES? () YES () NO
(Home Health Service includes any medical care or assistance by a nurse or doctor or therapist in your home.)

Have you received physical therapy for this condition before? () Yes () No

Please tell us how you heard about Iowa Therapy Group ?

Radio Ad ___ Newspaper Ad ___ Physician ___ Friend ___ Other _____

Medical History

Name: _____

Date: _____

Existing or Relevant Previous Conditions

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	MRSA	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	Muscular Disease	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Parkinsons	<input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disorder	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Smoking	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Speech Problems	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	High/Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	HIV/AIDS	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Incontinence	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Vision Problems	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? Yes No

Two or more falls in the last year? Yes No

Patient is at risk for falls? Yes No

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

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Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

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- Currently not taking any medications
- Are you pregnant
- Do you have a pacemaker

Iowa Therapy Group Functional Activities

Patient's Name: _____ Date: _____

Functional Activity	No Difficulty	Minimal Difficulty	Moderate Difficulty	Maximal Difficulty
1. Sitting	_____	_____	_____	_____
2. Standing	_____	_____	_____	_____
3. Walking in the Home	_____	_____	_____	_____
4. Walking in the Neighborhood	_____	_____	_____	_____
5. Using Stairs	_____	_____	_____	_____
6. Driving	_____	_____	_____	_____
7. Getting in/out of Car	_____	_____	_____	_____
8. Shopping	_____	_____	_____	_____
9. Rolling in Bed	_____	_____	_____	_____
10. Bathing	_____	_____	_____	_____
11. Grooming	_____	_____	_____	_____
12. Getting Dressed	_____	_____	_____	_____
13. Preparing food/Cooking	_____	_____	_____	_____
14. Reaching	_____	_____	_____	_____
15. Lifting/Carrying _____#	_____	_____	_____	_____

Iowa Therapy Group

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one, or all, of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

Patient Signature

Date