VICTORIA PHYSICAL THERAPY, P.C.

DeTar Medical Plaza
601 E. San Antonio St., Suite 301 W
Victoria, TX 77901

Phone: (361) 578-3513
Fax: (361) 578-4623

Referring Doctor: _____ Account #: _____

*****Are you currently receiving Home Health? Yes ☐ No ☐ IF YES, STOP HERE!!!*****

Have you had previous therapy for your injury? Yes ☐ No ☐ Date of Therapy: _____

Is the reason for today's visit work related? Yes ☐ No ☐ Date of Accident: _____

Is the reason for today's visit due to an automobile accident? Yes ☐ No ☐

Attorney Name: _____ Attorney Phone #: _____

Name: _____ SSN: _____

DOB: _____ Age: _____ DL #: _____

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone #: _____ Cell/Alternate Phone #: _____

Email Address: _____

Employer: _____ Occupation: _____

Work Address: _____ City/State: _____ Zip: _____

Work Phone #: _____

Spouse Name: _____ DOB: _____

Employer: _____ Occupation: _____

Work Address: _____ City/State: _____ Zip: _____

Work Phone #: _____

In case of an emergency, please notify: _____

Phone #: _____ Relationship to patient: _____

If patient is under 18, please list name of parent or guardian: _____

Primary Insurance: _____

Name of Person Insured: _____ DOB: _____

Policy #: _____ Group #: _____

Relationship to Patient: Self Spouse Dependent (Child)

Secondary Insurance: _____

Name of Person Insured: _____ DOB: _____

Policy #: _____ Group #: _____

Relationship to Patient: Self Spouse Dependent (Child)

AUTHORIZATION FOR CARE, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I give my consent to receive physical/occupational therapy treatment to be performed by the staff of Victoria Physical Therapy, P.C. I assign all payments to be paid directly to Victoria Physical Therapy, P.C. for all services described on the attached claim or statement. I further hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I acknowledge and understand that I am responsible for all the charges for all the services rendered to me or any member of my family.

Signature: _____ Date: _____

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PATIENT INFORMATION CONSENT FORM

I have read and fully understand Victoria Physical Therapy, PC's Notice of Information Practices. I understand that Victoria Physical Therapy, PC may obtain or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have to restrict how my personal health information is used and disclosed for treatment, payment and administration operations, if I notify the practice. I also understand that Victoria Physical Therapy, PC will consider requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Victoria Physical Therapy, PC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

MEDICAL RELEASE FORM

I, _____, give my permission to Victoria Physical Therapy, PC to obtain any and all medical records currently in your possession which are needed to assist in my care and treatment.

_____

Signature

_____

Date

Mary E. Drost, P.T.

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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.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date

My Medicine Record

These are my medicines as of: _____

NAME: _____ **BIRTH DATE:** _____

	NAME	DOSE	FREQUENCY	DOCTOR	MEDICAL CONDITION
Enter all prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine, and dietary supplements.					
EX	*Crestor*	*25 mg*	*Take orally 2 times a day*	*Dr. John Smith*	*Lower cholesterol*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

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MEDICAL SCREENING QUESTIONNAIRE

Date: _____

DOB: ____/____/_____

Name: _____

Gender: Male/Female **Age:** _____ **Smoker:** Yes/No **Pregnant:** Yes/No

Have you had any diagnostic imaging (X-Ray/MRI) or blood work for your current symptoms? Yes/No

Past Surgical History (include date):

_____
_____
_____
_____
_____

Explain your regular exercise routine:

_____
_____
_____
_____
_____

you take blood thinners? Yes/ No

e you allergic to latex? Yes/ No **Other allergies:** _____

es coughing, sneezing or taking a deep breath make your pain worse? Yes/ No

you have pain with bowl, bladder or sexually related activities/functions? Yes/ No

I am currently experiencing (check all that apply):

- ☐ Difficulty swallowing
- ☐ Numbness/tingling
- ☐ Depression
- ☐ Unexplained weight loss
- ☐ Nausea/vomiting
- ☐ Increased pain at night/rest
- ☐ Bowl/bladder changes
- ☐ Shortness of breath
- ☐ Changes in appetite
- ☐ Headaches
- ☐ Poor balance, falls or dizziness
- ☐ Pain with menstruation
- ☐ Vision changes
- ☐ Pain with eating

Where are you currently having symptoms? _____

Approximately what date did your present symptoms start? _____

How did your symptoms start? Gradual/sudden/injury _____

My symptoms are currently: Getting better/staying about the same/getting worse

Have you had these symptoms before? Yes/ No

Have you received other treatment for these symptoms? Yes/ No **If yes, did you get better?** Yes/ No

How do you sleep at night? Fine/moderate difficulty/only with medication

Do you have any learning barriers? Yes/ No **If yes, list:** _____

What are your personal goals for therapy? _____

_____

_____

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MEDICAL SCREENING QUESTIONNAIRE

During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes/No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes/No

Is this something with which you would like help? Yes, today/Yes, but not today/No help

On the scale below, please circle the number which best represents the severity of your pain:

***AVERAGE* for the past 48 hours:**

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

***BEST* for the past 48 hours:**

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

***WORST* for the past 48 hours:**

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Activities which make your pain worse (check all that apply):

- ☐ Lying down
- ☐ Bending
- ☐ Standing
- ☐ Walking
- ☐ Turning in bed
- ☐ Stress
- ☐ Sitting
- ☐ Reaching overhead
- ☐ Lifting
- ☐ Twisting

Any other activities that make your pain worse: _____

_____

Are there any activities that make your pain better? Yes/No **If yes, please list.** _____

_____

List the best and worst time of day for your pain. Best: _____

Worst: _____

On the scale below, circle the number which best represents your overall level of function:

Cannot do anything 1 2 3 4 5 6 7 8 9 10 Able to do everything

Use this space to explain and/or describe any other information you feel you want your therapist to know about your condition to better treat you.

_____

_____

_____

_____

_____

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MEDICAL SCREENING QUESTIONNAIRE

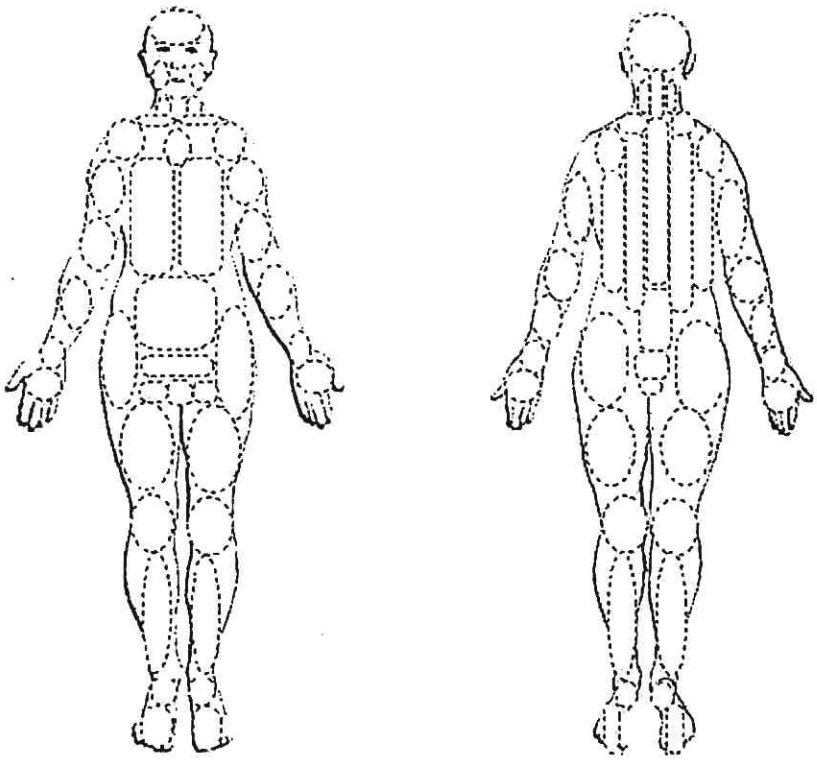
Other health problems that may affect your treatment (check all that apply):

- ☐ Arthritis (rheumatoid/osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), Acquired Respiratory Distress Syndrome (ARDS) or Emphysema
- ☐ Angina
- ☐ Congestive Heart Failure (or heart disease)
- ☐ Heart Attack (Myocardial Infarction)
- ☐ High Blood Pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Type I or II
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Pacemaker
- ☐ Visual Impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Hearing Impairment (very hard of hearing, even with hearing aids)
- ☐ Back Pain (neck pain, low back pain, Degenerative Disc Disease, Spinal Stenosis)
- ☐ Kidney, bladder, prostate or urination problems
- ☐ Previous accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Other disorders
- ☐ Hepatitis, Tuberculosis, HIV, AIDS or other blood-borne conditions
- ☐ Prior surgery
- ☐ Prosthesis/implants
- ☐ Sleep Dysfunction
- ☐ Cancer

PQRS Measure 131, Pain Assessment

Patient ID #:	Survey Date: _____/_____/_____

Please mark all of the areas where you are experiencing pain on the body part diagram below:



Please review all the qualities in the list below that describe your pain and circle the intensity for each one selected:

Throbbing	Severe	Moderate	Mild
Shooting	Severe	Moderate	Mild
Stabbing	Severe	Moderate	Mild
Sharp	Severe	Moderate	Mild
Cramping	Severe	Moderate	Mild
Gnawing	Severe	Moderate	Mild
Hot / Burning	Severe	Moderate	Mild
Aching	Severe	Moderate	Mild
Heavy	Severe	Moderate	Mild
Tender	Severe	Moderate	Mild
Splitting	Severe	Moderate	Mild
Tiring / Exhausting	Severe	Moderate	Mild
Sickening	Severe	Moderate	Mild
Fearful	Severe	Moderate	Mild
Punishing / Cruel	Severe	Moderate	Mild

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