DuVal
INTEGRATIVE PHYSICAL THERAPY

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Patient Information

Welcome! Thank you for selecting our practice. In order to serve you properly, we will need the following information. All information will be kept strictly confidential. (Please print clearly.)

Patient Name _____

Street Address _____

City _____ State _____ Zip/Postal Code _____

Phone: (Home) _____ (Cell) _____ (Fax) _____

Email _____

Date of Birth _____ (M/D/YR) (Circle) Male / Female

Marital Status: (Circle) Single Married Divorced Separated Widowed Partner

If Child, Parent/Guardian's Name _____

Employer _____ Occupation_____

Address _____ Phone _____

Insurance Carrier(s) _____

Are you submitting for out of network reimbursement? ☐ Yes ☐ No

Please provide us with the name of someone to contact in case of emergency:
Name _____
Phone _____
Relationship _____

I understand that payment is expected on the day of each treatment, with the exception of Worker's Compensation insurance coverage. I am responsible for all charges, regardless of insurance coverage. I understand that DuVal Integrative Physical Therapy is not a Medicare or Medicaid provider. I understand that DuVal Integrative Physical Therapy expects prompt payment of all bills for services rendered. I am responsible for prompt payment for all such bills.

Patient/Guardian Signature _____ Date _____

INTAKE INFORMATION

_____ _____ _____

Date Patient Name Current Age

Please complete the following information in detail. This will assist us in designing the most effective and efficient individualized program for you. Every item is significant and important. Thank you for your effort. Please print neatly.

Who recommended you to this office? ☐ Physician ☐ Family/Friend ☐ Website ☐ Advertisement

Official Diagnosis or Main Problem: _____

_____

IMPORTANT:

To the patient: Please list below the main complaints/challenges you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

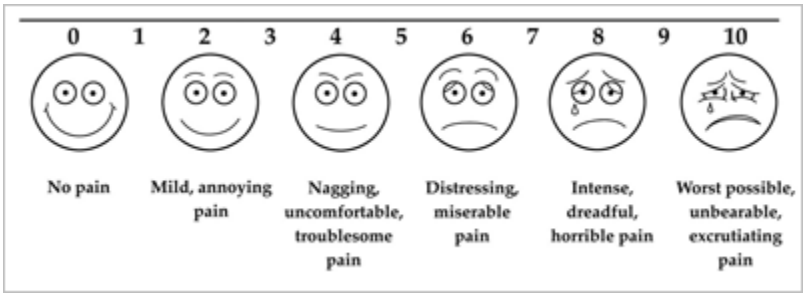
Date of Onset: _____

When did your pain begin? (Weeks, Months, Years ago?) _____

Was there an injury/how did your pain being? _____

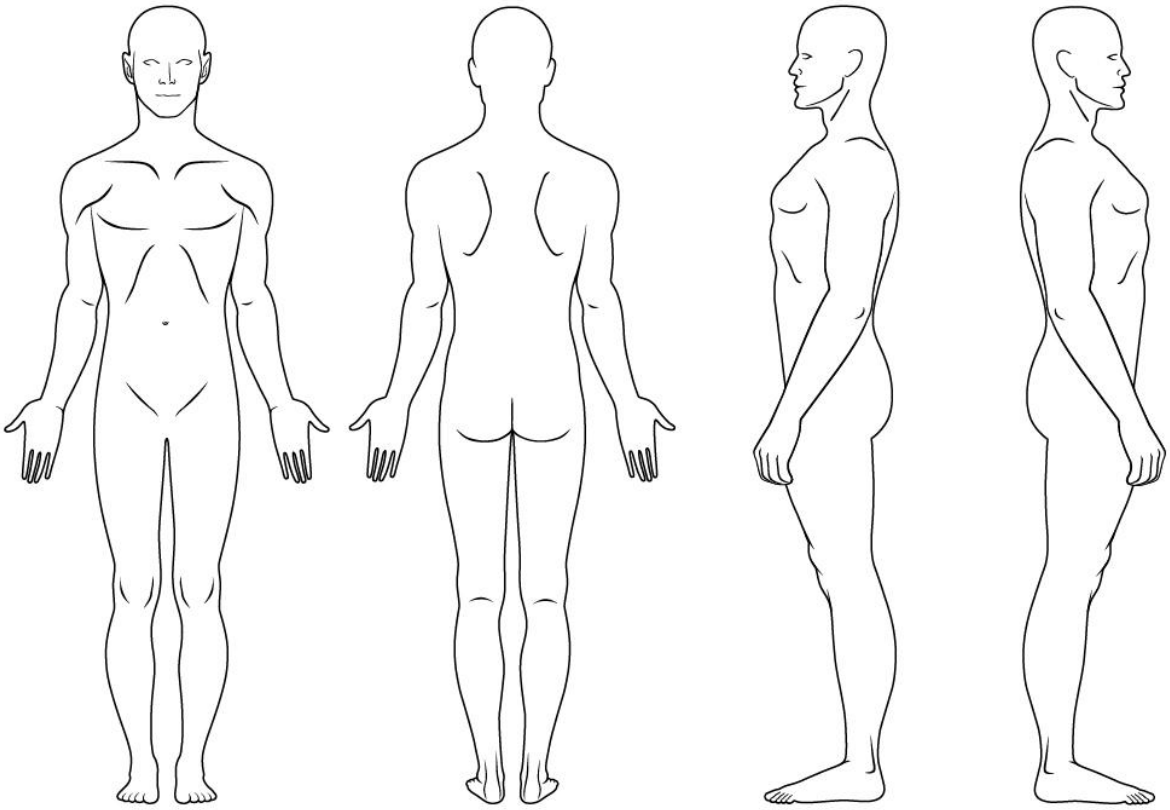
_____

_____



Areas of pain	Today	At Its Least	At Its Worst
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

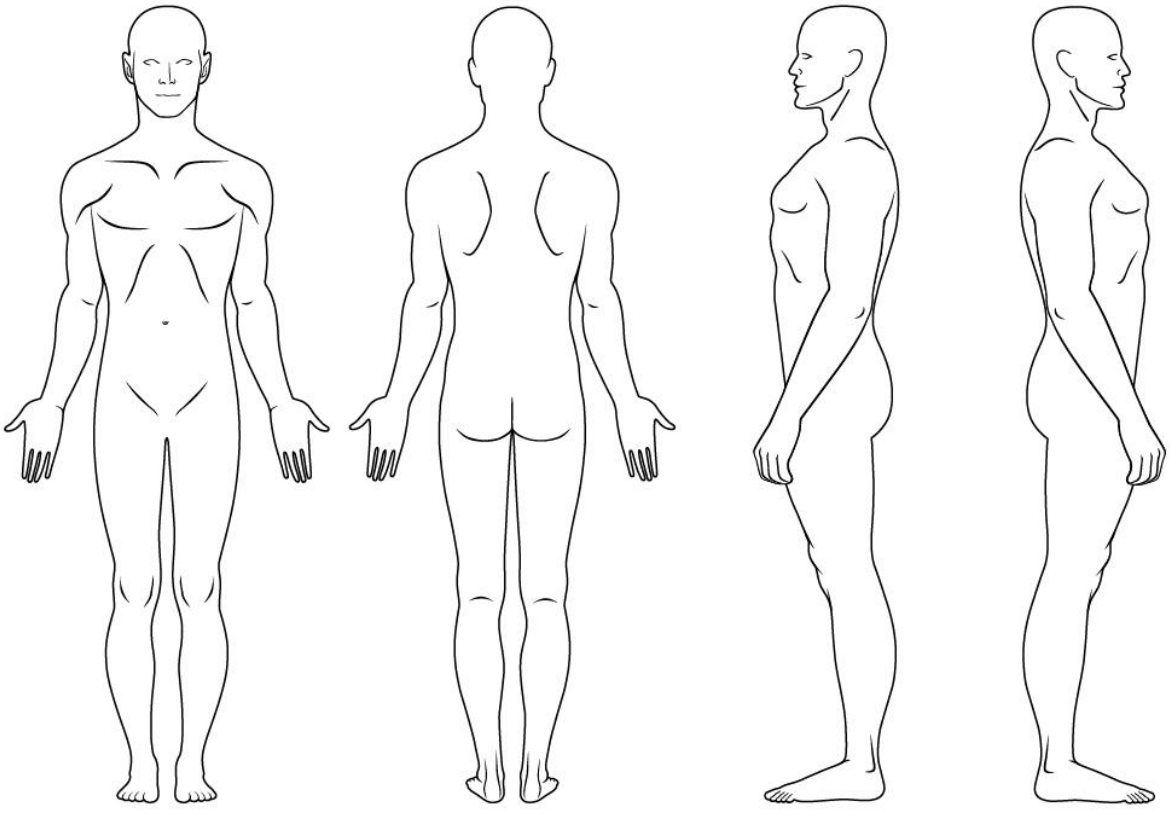
Please mark areas of pain on diagrams below:



Paresthesia: Please check the following areas of "funny feeling" (tingling, burning, pins and needles, etc.)

☐ Head	☐ Right Lower Arm	☐ Right Front Thigh
☐ Face	☐ Left Lower Arm	☐ Left Front Thigh
☐ Jaw	☐ Right Wrist	☐ Right Back Thigh
☐ Front of Neck	☐ Left Wrist	☐ Left Back Thigh
☐ Back of Neck	☐ Right Fingers	☐ Right Knee
☐ Right Side of Neck	☐ Left Fingers	☐ Left Knee
☐ Left Side of Neck	☐ Upper Back	☐ Right Shin
☐ Right Shoulder	☐ Chest/Rib Cage	☐ Left Shin
☐ Left Shoulder	☐ Abdomen	☐ Right Foot
☐ Right Upper Arm	☐ Low Back	☐ Left Foot
☐ Left Upper Arm	☐ Buttocks	☐ _____
☐ Right Elbow	☐ Right Hip	☐ _____
☐ Left Elbow	☐ Left Hip	☐ _____

Paresthesia Diagram: Please shade in all reas of "funny feeling" (tingling, burning, pins and needles, etc.)



Function: Activities of daily living (ADLs) are compromised as follows:

Please indicate what your functional limitations are: ___Dressing ___Bathing ___Cooking ___Cleaning ___Yard Work ___Stairs ___Lying Down ___Sitting ___Standing ___Walking ___Driving ___Running ___Working ___Sports & Leisure Activities ___Time of Day ___Too Much Activity ___Bending ___Reaching ___Lifting ___Squatting ___Kneeling ___Too Little Activity ___ Sleeping ___ Other (Specify):

_____

_____

☐ **All activities/ADL's** are performed despite ☐ pain ☐ fatigue ☐ lack of energy
☐ headaches ☐ painful ☐ difficult

Current Assistive Devices: ☐ None

Cane	☐ Yes ☐ No	Dentures	☐ Yes ☐ No
Walker	☐ Yes ☐ No	Prosthetics	☐ Yes ☐ No
Manual Wheelchair	☐ Yes ☐ No	Shunts	☐ Yes ☐ No
Motorized Wheelchair	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Corrective Lenses/Glasses	☐ Yes ☐ No	Insulin Pump	☐ Yes ☐ No
Hearing Aids	☐ Yes ☐ No	Baclofen Pump	☐ Yes ☐ No

Other: _____

What was your prior level of functioning?

_____

_____

Relevant Medical Tests:

_____

_____

Current and Past Medical History:

☐ Headaches/Frequency: _____ Duration _____ Intensity Range 0-10 _____
☐ Migraine Headaches/Frequency: _____ Duration: _____ Intensity/Range 0-10: _____

☐ Alcoholism	☐ Back Pain
☐ Allergies	☐ Bronchitis
☐ Alzheimer's Disease	☐ Cancer/What Type
☐ Arthritis	☐ Carpal Tunnel Syndrome
☐ Asthma	☐ Cerebral Palsy
☐ Attention Deficit Disorder (ADD)	☐ Cholesterol, Elevated
☐ Attention Deficit Hyperactivity Disorder	☐ Chronic Fatigue Syndrome
☐ Autoimmune Disease	☐ Circulatory Problems
☐ Colitis	☐ Depression
☐ Dental Problems	☐ Diabetes

☐ Diverticular Disease
☐ Drug Addiction
☐ Eating Disorder
☐ Epilepsy
☐ Environmental Sensitivities
☐ Eyes, Ears, Nose, Throat Problems
☐ Fibromyalgia
☐ Food Intolerance
☐ Gastrointestinal
☐ Genetic Disorder
☐ Glaucoma
☐ Gout
☐ Heart Disease
☐ High Blood Pressure
☐ Infection, Chronic (Type)
☐ Inflammatory Bowel Disease
☐ Irritable Bowel Syndrome
☐ Kidney or Bladder Disease
☐ Learning Disabilities
☐ Liver or Gallbladder Disease (Stones)
☐ Lymphedema
☐ Lymphatic Problems
☐ Mental Illness
☐ Mental Retardation
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Musculoskeletal Problems
☐ Obesity
☐ Osteoporosis
☐ Paraplegia
☐ Parkinsons
☐ Phobias
☐ Pneumonia
☐ Quadriplegia
☐ Respiratory Problems
☐ Rheumatoid Arthritis
☐ Seasonal Affective Disorder
☐ Sexually Transmitted Disease
☐ Sinus Problems
☐ Skin Problems
☐ Spina Bifida
☐ Stroke
☐ Thyroid Trouble
☐ Traumatic Brain Injury (TBI)
☐ Tuberculosis
☐ Ulcer
☐ Urinary Tract Infection
☐ Varicose Veins
☐ Other
☐ Other
☐ Other

Medical (Women):

☐ Breast Cancer
☐ Breast Surgery/Reduction/Implants
☐ Decreased Sex Drive
☐ Endometriosis
☐ Fibrocystic breasts
☐ Fibroids/Ovarian Cysts
☐ Infertility
☐ Menstrual irregularities
☐ What was the date of onset of last menses?
☐ Pelvic Inflammatory Disease
☐ PMS
☐ Sexually Transmitted Disease
☐ Vaginal Infections
☐ Other
☐ Other

Medical (Men):

☐ Benign Prostatic Hypertrophy
☐ Decreased Sex Drive
☐ Infertility
☐ Prostate Cancer
☐ Sexually Transmitted Disease
☐ Other
☐ Other

Past Surgeries/Procedures:

List any operations you have undergone and dates (approximately): _____
_____
_____
_____
_____
_____

List any hospitalizations and dates (approximately): _____
_____
_____
_____
_____
_____

Past Trauma (Physical/Emotional):
List all trauma and when it occurred (All trauma, accidents injuries are important, not just recent ones): _____
_____
_____
_____
_____
_____

Social History:
How many hours do you sleep at night? _____

How would you consider your present level of activity? ____ Poor ____ Fair ____ Good

Please describe your present living situation:

☐ Apartment ☐ 1 Story
☐ House ☐ 2 Story
☐ Lives Alone
☐ Lives with Spouse/Family/Roommate

Present Home Environment:

Stairs, no railing	☐ Yes	☐ No
Stairs, railing	☐ Yes	☐ No
Ramps	☐ Yes	☐ No
Elevator	☐ Yes	☐ No
Uneven Terrain	☐ Yes	☐ No
Bathroom modifications	☐ Yes	☐ No

Any other obstacles:
_____
_____

Exercise: (Check all that apply)

☐ 5-7 days per week
☐ 3-4 days per week
☐ 1-2 days per week
☐ Infrequent
☐ Never

☐ 45 minutes or more duration per workout
☐ 30-45 minutes duration per workout
☐ Less than 30 minutes
☐ Cannot tolerate

Nutrition and Diet:

☐ Vegetarian
☐ Vegan
☐ High Protein
☐ Salt Restriction
☐ Low Fat Diet
☐ Starch/Carbohydrate Restriction
☐ Diabetic Diet
☐ Other: _____

Specific Food Restrictions:

☐ Dairy ☐ Eggs ☐ Soy ☐Corn ☐All Gluten ☐ Wheat ☐ Sugar
☐ Other: _____

Health Habits:

☐ Tobacco: Cigarettes #/day _____ Cigars #/day _____ Pipe _____ Chewing _____
☐ Alcohol
☐ Caffeine
☐ Soda w/caffeine: ☐ Diet Sodas
☐ Other: _____

Circle the level of stress you are experiencing on a scale of 1-10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):

_____
_____
_____

Work/Occupation:

Please state what you do for a living: _____

Please indicate the hours you spend at work per week: _____

Are you a full time homemaker? ☐ Yes ☐ No

Or

If you are currently not working, how long have you not worked? _____

Are you not working for reasons other than your pain/problem? ☐ Yes ☐ No
If so, what reason? _____
_____

Are you presently receiving compensation (disability insurance)/ ☐ Yes ☐ No

If not, are you considering or have you applied for compensation of any kind? _____
_____

If you anticipate returning to work, when do you hope to do so? _____
_____

Family Health History:

☐ Alcoholism
☐ Alzheimer's Disease
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug Addiction
☐ Eating Disorder
☐ Genetic Disorder
☐ Glaucoma
☐ Heart Disease
☐ High Blood Pressure
☐ Infertility
☐ Learning Disabilities
☐ Mental Illness
☐ Migraine Headaches
☐ Neurological Disorders (Parkinson's, Paralysis)
☐ Obesity
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Stroke
☐ Other

Medications/Supplements
List any prescribed, over the counter medications and/or supplements you are taking:

Name of those taking currently	Dosage	Frequency?	Administered how (oral, injection, etc.)?

☐ Attach a piece of paper if needed.

Prior Therapy/Procedures:

Follow up Date with Referring MD:

Are you seeing any other doctors or health care professionals now for any reason? (Note: These practitioners will not be contacted without your permission.) ☐ Yes ☐ No

Practitioner's Name	Type of Practitioner:
_____	_____
_____	_____
_____	_____

Patient Goals:
While you are a patient here at DuVal Integrative Physical Therapy a goal list will help us recognize what you would like to accomplish. Your therapist will evaluate you with your input in mind. **"Patient Centered Goals"** will serve as the basis for treatment. Goals will be revised as needed.

Please fill in the following so the therapist can consider your desires/goals.
The following examples are provided to assist you to answer.

I know I will be better when I can:
Example 1. Walk independently for 15 minutes with no pain.
Example 2. Work using just a splint for a half day with occasional pain.
Example 3. Sit with the help of only one person for 30 seconds.
Example 4. Play 18 holes of golf without pain in my back.

Please fill in the chart below, answering "I know I will be better when I can:

1. _____
2. _____
3. _____
4. _____
5. _____