RIVER VALLEY
PHYSICAL THERAPY

River Valley Physical Therapy
517 East North Street
Bradley, IL 60915

Phone: (815) 802-7503
Fax: (815) 802-7514

PATIENT CONTACT INFORMATION

First Name: _____ **Middle Initial**: _____ **Last Name**: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Home Phone: ( ) _____ **Work Phone**: ( ) _____

Cell Phone: ( ) _____ **Email**: _____

Date of Birth: ____/____/____ **Age**: _____ years **Sex**: □ Male □ Female

Height: _____ **Weight**: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone: ( ) _____

How did you hear about our clinic?: _____

EMPLOYER INFORMATION

Employment Status: □ Employed □ Full Time Student □ Part Time Student □ Other

Name: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Occupation: _____ **Work Phone**: ( ) _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Member ID#: _____ **Group #**: _____

Policy Holder: _____ **Policy Holder D.O.B.**: ____/____/____

Relationship to Patient (if not self): _____

Policy Holder Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Policy Holder Phone: ( ) _____

CASE INFORMATION

Using the scale to the right, how would you grade your pain in the LAST 48 HOURS?
(*please enter only 1 number on the line behind each question)*

0	NO PAIN
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	WORST PAIN

At best? _____

At worst? _____

At the moment? _____

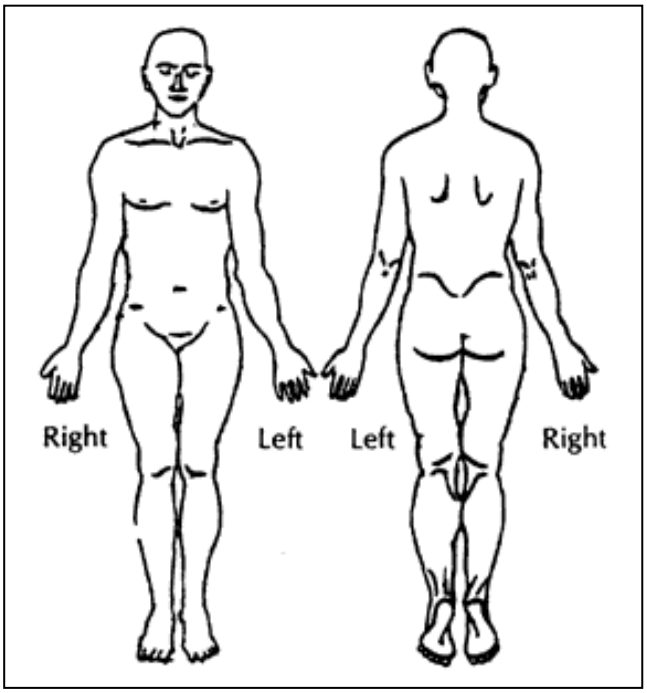
Describe your pain in the last 48 hours:

□ SHARP □ DULL

□ CRAMPING □ ELECTRICAL

□ LOCALIZED □ RADIATING

In the body chart to the right, please draw the area(s) of discomfort or pain.



Have you fallen in the past year? YES/NO

If so, how many times? _____

Why did you fall? _____

_____

Are you currently receiving any form of Home Health Care? (PT, OT, RN) YES/NO

Describe your symptoms: _____

_____

_____

When did your problem begin? Date: _____ If no date: # of weeks ago:___ # of months ago:___

How did your symptoms begin? _____

What eases or makes your problem better? _____

What aggravates or makes your problem worse? _____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occassionally (26-50% of the day) □ Intermittently (0-25% of the day)

How are your symptoms changing?

□ Getting Better □ Not Changing □ Getting Worse

What tests have you had for your symptoms?

□ X-rays □ MRI □ CT Scan □ Other

Who have you seen for your symptoms?

□ Medical Doctor □ Physical Therapist □ Chiropractor □ No One □ Other

Have you had previous treatment for your symptoms?

□ Physical Therapy □ Chiropractic □ Medication □ Surgery □ Other

In general, would you say your overall health right now is...

□ Excellent □ Very Good □ Good □ Fair □ Poor

MEDICAL HISTORY INFORMATION

Have you had trouble with any of the following?

Cardiovascular: ☐ NO

	Present	Past	No
Poor Circulation	☐	☐	☐
High Blood Pressure	☐	☐	☐
Aortic Aneurysm	☐	☐	☐
Heart Disease	☐	☐	☐
Heart Attack	☐	☐	☐
Chest Pain	☐	☐	☐
High Cholesterol	☐	☐	☐
Pace Maker	☐	☐	☐
Jaw Pain	☐	☐	☐
Irregular Heartbeat	☐	☐	☐
Swelling of Legs	☐	☐	☐

Gastrointestinal: ☐ NO

	Present	Past	No
Gallbladder Problems	☐	☐	☐
Bowel Problems	☐	☐	☐
Constipation	☐	☐	☐
Liver Problems	☐	☐	☐
Ulcers	☐	☐	☐
Diarrhea	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Bloody Stools	☐	☐	☐
Poor Appetite	☐	☐	☐

Hematologic/lymphatic: ☐ NO

	Present	Past	No
Hepatitis	☐	☐	☐
Blood Clots	☐	☐	☐
Cancer	☐	☐	☐
Easy bruising	☐	☐	☐
Easy Bleeding	☐	☐	☐
Fever/Chills/Sweats	☐	☐	☐

Integumentary: ☐ NO

	Present	Past	No
Skin Ulcers	☐	☐	☐
Skin Disease	☐	☐	☐
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
Rashes	☐	☐	☐

Respiratory: ☐ NO

	Present	Past	No
Asthma	☐	☐	☐
Tuberculosis	☐	☐	☐
Shortness of Breath	☐	☐	☐
Emphysema	☐	☐	☐
Cold/Flu	☐	☐	☐
Cough/Wheezing	☐	☐	☐

Ears/Nose/Throat: ☐ NO

	Present	Past	No
Dizziness	☐	☐	☐
Hearing Loss	☐	☐	☐
Sinus Infection	☐	☐	☐
Nosebleed	☐	☐	☐
Sore Throat	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Bleeding Gums	☐	☐	☐

Neurologic: ☐ NO

	Present	Past	No
Stroke	☐	☐	☐
Seizures	☐	☐	☐
Head Injury	☐	☐	☐
Brain Aneurysm	☐	☐	☐
Numbness	☐	☐	☐
Severe Headaches	☐	☐	☐
Pinched Nerves	☐	☐	☐
Parkinson's Disease	☐	☐	☐
Carpal Tunnel	☐	☐	☐
Spinning/Balance	☐	☐	☐

Psychiatric: ☐ NO

	Present	Past	No
Depression	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Unusual Stress	☐	☐	☐

Constitutional: ☐ NO

	Present	Past	No
Weight Loss/Gain	☐	☐	☐
Energy Level Problem	☐	☐	☐
Difficulty Sleeping	☐	☐	☐

Allergic/Immunologic: ☐ NO

	Present	Past	No
Hives	☐	☐	☐
Immune Disorder	☐	☐	☐
HIV/AIDS	☐	☐	☐
Allergy Shots	☐	☐	☐
Cortisone Use	☐	☐	☐

Genitourinary: ☐ NO

	Present	Past	No
Kidney Disease	☐	☐	☐
Lower Side Pain	☐	☐	☐
Burning Urination	☐	☐	☐
Frequent Urination	☐	☐	☐
Blood in Urine	☐	☐	☐
Kidney Stone	☐	☐	☐

Musculoskeletal: ☐ NO

	Present	Past	No
Gout	☐	☐	☐
Arthritis	☐	☐	☐
Joint Stiffness	☐	☐	☐
Muscle Weakness	☐	☐	☐
Osteoporosis	☐	☐	☐
Broken Bones	☐	☐	☐
Joints Replaced	☐	☐	☐

Endocrine: ☐ NO

	Present	Past	No
Thyroid Disease	☐	☐	☐
Diabetes	☐	☐	☐
Hair Loss	☐	☐	☐
Menopausal	☐	☐	☐
Menstrual Problems	☐	☐	☐

Eyes: ☐ NO

	Present	Past	No
Glaucoma	☐	☐	☐
Double Vision	☐	☐	☐
Blurred Vision	☐	☐	☐

Please list your past surgical history: _____

_____

_____

Is there anything else we should be aware of while treating you, which could affect your rehabilitation? _____

_____

_____

MEDICATION INFORMATION

Please list your current medication information below: *(use back of page if more space is needed)*

MEDICATION	DOSAGE	FREQUENCY	METHOD OF ADMINISTRATION
		□ As Needed □ Once Daily □ Twice Daily □ Three Times Daily □ Other: ______________	□ Oral □ Sublingual □ Topical □ Subcutaneous Injection □ Other: _________________
		□ As Needed □ Once Daily □ Twice Daily □ Three Times Daily □ Other: ______________	□ Oral □ Sublingual □ Topical □ Subcutaneous Injection □ Other: _________________
		□ As Needed □ Once Daily □ Twice Daily □ Three Times Daily □ Other: ______________	□ Oral □ Sublingual □ Topical □ Subcutaneous Injection □ Other: _________________
		□ As Needed □ Once Daily □ Twice Daily □ Three Times Daily □ Other: ______________	□ Oral □ Sublingual □ Topical □ Subcutaneous Injection □ Other: _________________
		□ As Needed □ Once Daily □ Twice Daily □ Three Times Daily □ Other: ______________	□ Oral □ Sublingual □ Topical □ Subcutaneous Injection □ Other: _________________

PATIENT/GUARDIAN CONSENT

By signing below, you agree to the following:

I authorize release of information requested by my insurance plan for payment.
I understand that I am responsible for any balance due.
I agree to comply with the terms and conditions as outlined in the Patient Registration form.
I consent to physical therapy evaluation and treatment.
I understand that my care may be discontinued after 3 unexplained absences if I do not call within 24 hours of the scheduled treatment time to give notice of my absence or attempt to reschedule my appointment time.

Notice of Privacy Practices:

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Signature of Patient or Guardian: ____ **Date:** _____/______/________

To receive appointment reminders, please circle your preferred method of contact: TEXT - CALL - EMAIL