Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
First Name Used:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Legal Sex: Assigned Sex at Birth:
Gender Identity: Male____ Female____
Transgender Male____ Transgender Female____
Gender Non-conforming____ Self Identify _____
Sexual Orientation: Heterosexual____ Homosexual____ Bisexual____
Other____ Do Not Know____ Choose Not To Disclose____
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language: Race:
Ethnicity: **Relationship Status:**

Guarantor Information (to whom statements are sent)

Name:
Address:
Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone: **Mobile Phone:**

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by:
Primary Care Provider:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:
Crossroads:
Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Gender on Insurance (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Gender on Insurance (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

ACKNOWLEDGEMENT AND AUTHORIZATION:

- Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more full described in Des Moines University's Notice of Privacy Practices (NPP). Des Moines University is permitted to revise its NPP at any time. We will provide you with a copy of the revised NPP upon your request.

By signing below, you are acknowledging that you have received a copy of Des Moines University's Notice of Privacy Practices

Signed_____ **Date:**_____

- I understand that I am financially responsible to pay Des Moines University it's usual charges for all services received through Des Moines University, including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Des Moines University, and direct that payment of proceeds be made directly to Des Moines University.

- I authorize the release of medical record information or excerpts thereof to any insurance company or third party payor for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization, per HIPAA regulations.

- I authorize Des Moines University Clinic to obtain/have access to my medication history.

- I authorize the healthcare providers of DMU Clinic to administer treatment as deemed necessary for my care. As a teaching institution, students may be involved in my care. I certify that no guarantee has been made as to the results that may be obtained from the treatment. This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Signed_____ **Date:**_____

Medicare Secondary Payer Questionnaire: To be completed by patients who present with Medicare insurance products.

1. Do you have any group health insurance coverage based upon your current or former employment? Yes ____ No ____

2. Do you have any group health insurance coverage based upon your spouse or other family member's current employment? Yes ____ No ____

3. Are you receiving any of the following benefits?

Black Lung	Yes ____	No ____
Veterans Administration	Yes ____	No ____
End Stage Renal Disease	Yes ____	No ____

4. Is this service related to an automobile injury or illness? Yes ____ No ____
Is this service related to a work-related injury or illness? Yes ____ No ____
Is this service related to any other third party liability injury or illness? Yes ____ No ____

If you have answered yes to any of the above questions, we will request further benefit information.

Des Moines University Clinic
3200 Grand Ave
Des Moines, IA 50312

COMMUNICATION FORM

I give permission for DMU clinic employees to contact me and leave messages in the manner listed below as it relates to my care at Des Moines University Clinic.

CONTACT INFORMATION:

Home Phone #:	May clinic staff leave a message at this number? □ Yes □ No
Work Phone #:	May clinic staff leave a message at this number? □ Yes □ No
Mobile Phone #:	May clinic staff leave a message at this number? □ Yes □ No

Please indicate your primary contact preference: □ Home # □ Work # □ Mobile # □ Mail □ Portal

Email address:_____

AUTOMATED MESSAGING PREFERENCES: Please indicate how you would like to receive automated messages. You can choose more than one option; for example, you can get appointment reminders via Email, phone, and text messaging. If you do not check an option in a category below, you have "Opted Out" of receiving messages for that category: example if you do not check an option under Announcements you will not receive any announcements.

Health Notifications:	□ Email □ Phone* □ Text Message*
Appointment:	□ Email □ Phone* □ Text Message*
Announcements:	□ Email □ Phone* □ Text Message*
Billing:	□ Email □ Phone* □ Text Message*

*If you checked any "text message" box above, you are giving DMU permission to send a text to your mobile number.
*If you checked any "phone" box above and we have your mobile number listed, you are giving DMU permission to call your mobile number.

To change any of your communication preferences, including enrolling in text message appointment reminders, log in to your "My DMU Chart" portal account and indicate your Contact Preferences under the My Profile tab.

I have designated the people listed below as being involved in my health care. They may also be privy to any related financial or insurance information at DMU Clinic. I give DMU permission to disclose this information with these designated people.

Name	Phone Number	Relationship	May a message be left at this number?
			□ Yes □ No
			□ Yes □ No

The people listed below **MAY NOT** have access to my health care and financial / insurance information at DMU. For termination of parental rights, we must have the supporting legal documentation on file. If we do not have the supporting legal documentation on file, both parent will have access to medical / financial / insurance information.

Name	Relationship (e.g. parent, guardian)

_____ _____

Patient or legal representative signature **Date**

Patient: _____ Height: _____
Date:_____ DOB: _____ Weight: _____

Des Moines University Clinic
3200 Grand Avenue
Des Moines, IA 50312
(515) 271-1717

Physical Therapy Intake Report

****Have you been treated at another rehab/therapy facility for the current year: Yes No**

1. When and how did this start? Date: __/__ /__ Circle one: Gradual Sudden Traumatic

2. What (position, activity, movement) makes you feel worse?

3. What makes you feel better?

4. Do you have any other medical concerns/conditions?

5. What are your goals for therapy?

Allergies to medications/tape/latex:
(write NKDA if none known)

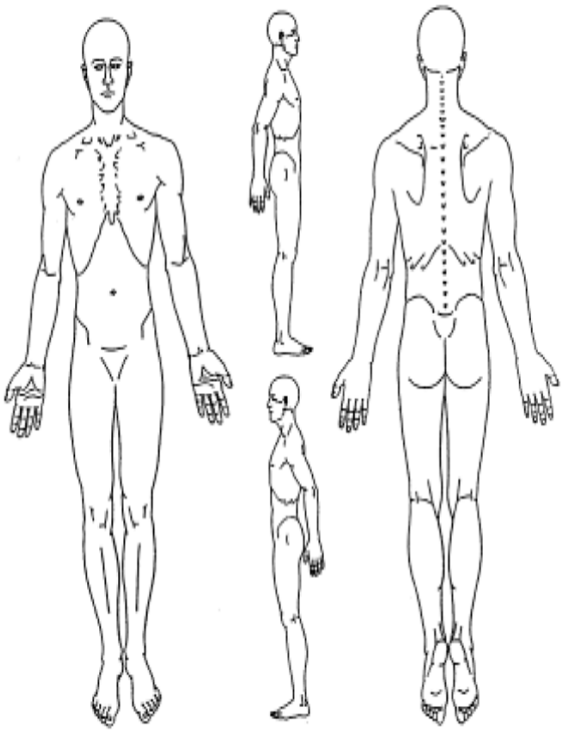
Medications:
(write "none" if none)

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. **Be VERY precise when drawing the location of your pain.** Use the key to indicate the type of symptoms.

Key

AAA = Ache BBB = Burning NNN = Numbness PPP = Pins & needles

SSS = Stabbing WWW = Weakness OOO = Other (PT, please clarify)



Please rate your current level of pain on the following scale (check **one**):

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
(no pain)										*(worst imaginable pain)*

Please rate your worst level of pain in the last 24 hours on the following scale (check **one**):

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
(no pain)										*(worst imaginable pain)*

Please rate your lowest level of pain, including no pain, in the last 24 hours on the following scale (check **one**):

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
(no pain)										*(worst imaginable pain)*

Patient Signature Date

DES MOINES UNIVERSITY

Welcome to our practice!!

Please fill out all the following information:

Date _____

Name _____

Date of Birth _____

Signature _____

Sex ☐ Male ☐ Female

Occupation _____

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Do you have an advance directive or a living will?

☐ Yes ☐ No

Please indicate any religious, cultural, or spiritual values you wish to be considered in your health care treatment decision making:

_____

_____

_____

Medications, Allergies, and Immunizations

Please list all current medications. Please include all prescription and over the counter drugs as well as birth control pills, herbal medications, and vitamins.

Medication	**Dosage/How Often**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

Allergies	**Reaction**
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY (circle yes or no)

DRUG/ALCOHOL USE		
Do you or have you ever smoked?	**YES**	**NO**
If yes, how many cigarettes a day?		
If former smoker, when did you quit?		
If former smoker, how long did you smoke?		
Do you drink alcohol?	**YES**	**NO**
Do you use illegal drugs?	**YES**	**NO**
Do you drink caffeine?	**YES**	**NO**
If yes, how much per day?		
Do you exercise?	**YES**	**NO**
If yes, what activity? CIRCLE Jogging, Running, Cycling, Spinning, Aerobics, Step, Tennis, Racquetball, Weights, Martial Arts, Other		
How many days per week?		
Time/duration (minutes)?		

Current Diet: _____

_____

Do you have any dietary restrictions? Yes No

If yes, please explain: _____

_____

DES MOINES UNIVERSITY

Welcome to our practice!!

Past Medical History

Please check if YOU have had any of the following:

Abuse (physical)			Heart Disease		
Abuse (sexual)			Hemorrhoids		
AIDS			High Blood Pressure		
Alcoholism			High Cholesterol		
Alzheimer's			Joint Pain		
Anemia			Kidney Disease		
Anesthesia Complications			Kidney Stones		
Anxiety			Migraines		
Asthma			Osteoporosis		
Back Pain			Pneumonia		
Blood Disorder			Prostate Problems		
Blood Clots			Reflux (gastric)		
Blood Transfusions			Seasonal Allergies		
Cancer			Seizures		
Type:			Sexually Transmitted Disease		
Dementia			Stroke		
Depression			Thyroid Disease		
Diabetes			Urinary Incontinence		
Emphysema			Other		
Eye Disease					
Glaucoma					

Hospitalizations:

Date (mo/year) **Reason**

_____/_____ _____

_____/_____ _____

_____/_____ _____

_____/_____ _____

Comments on Past Medical History:_____

_____

_____

_____

WOMEN ONLY

Gynecologic History

No. of Pregnancies	
Still Births	
Live Births	
Abortions	
Miscarriages	

Past Surgical History

Please check the box if you have had the surgery and then indicate the year if you know it.

SURGERY	Y	YEAR	SURGERY	Y	YEAR
Appendix			Joint		
Back Surgery			Prostate		
Breast Problems / Surgeon			Tonsils		
Ears			Tubal-ligation		
Eyes			Vasectomy		
Foot Trauma			Wisdom Teeth		
Gall Bladder			Other Surgery:		
Heart Bypass					
Hernia Repair					
Hysterectomy					

Pelvic Floor Distress Inventory Questionnaire-(Pediatrics)

Please answer all questions in the following survey. These questions will ask you if you have certain, bowel, bladder, or pelvic symptoms and if you do how much they bother you. Answer each questions by marking an appropriate circle. If you are unsure how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the last 3 months.

	If yes, how much does it bother you?	Not at all	Somewhat	Moderately	Quite a bit
1. Do you feel you need to strain to have a bowel movement?	Yes ◯ No ◯	◯	◯	◯	◯
2. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	Yes ◯ No ◯	◯	◯	◯	◯
3. Do you usually lose stool beyond your control if your stool is well formed?	Yes ◯ No ◯	◯	◯	◯	◯
4. Do you usually lose stool beyond your control if your stool is loose or liquid?	Yes ◯ No ◯	◯	◯	◯	◯
5. Do you usually lose gas from the rectum beyond your control?	Yes ◯ No ◯	◯	◯	◯	◯
6. Do you usually have pain when you pass your stool?	Yes ◯ No ◯	◯	◯	◯	◯
7. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	Yes ◯ No ◯	◯	◯	◯	◯
8. Does part of your stool every pass through the rectum and bulge outside during or after a bowel movement?	Yes ◯ No ◯	◯	◯	◯	◯
9. Do you usually experience frequent urination?	Yes ◯ No ◯	◯	◯	◯	◯
10. Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	Yes ◯ No ◯	◯	◯	◯	◯
11. Do you usually experience urine leakage related to laughing, coughing, or sneezing?	Yes ◯ No ◯	◯	◯	◯	◯
12. Do you usually experience small amounts of urine leakage? (drops)	Yes ◯ No ◯	◯	◯	◯	◯
13. Do you usually experience difficulty emptying your bladder?	Yes ◯ No ◯	◯	◯	◯	◯
14. Do you usually experience pain or discomfort in the lower abdomen or genital region?	Yes ◯ No ◯	◯	◯	◯	◯

Scale scores- The mean value of all questions answered is then multiplied by 25 for the actual score (range 0 to 100)