DES MOINES UNIVERSITY CLINIC

OFFICE USE ONLY

Date	Account #	Doctor

PATIENT INFORMATION

First Name (Legal)	Middle Name	Last Name	Previous Name	Age	Date of Birth	Sex	Marital Status

Address - Street	Apt. #	Patient Cell Phone	
City	State / Zip	Patient Employer	Patient Work Phone
Phone Number This phone # will be used for appt. reminders	Social Security Number	Employer Address	
In Case of Emergency (Friend or Relative who does not live with you) Name and Relationship	Phone #	Mom's Cell Phone #	Dad's Cell Phone #
Spouse's Name/Parent's Name (if under 18)	Spouse/Parent Employer Name	Spouse / Parent Employer Phone #	Student Status part-time ____ full-time ____
Please specify the race you most closely identify with	Preferred Language	Do you consider yourself to be ethnically Hispanic or Latino? ☐Yes ☐No	

BILLING INFORMATION

Responsible Party/Custodial Parent (If same as above, skip to insurance information)	Phone Number	Relationship to Patient ☐(1) Self ☐(2) Spouse ☐(3) Child ☐(9) Other
Street Address	Responsible Party's Employer	Phone Number
City / State / Zip		

PRIMARY INSURANCE

Insurance Company Name & Address	
Effective Date	Expiration Date
Policy Holder's Name	Relationship to Patient
Policy Number	Group Number
Policy Holder's SS Number	Policy Holder's Date of Birth
Policy Holder's Employer Name	
Phone Number	

WORKERS COMPENSATION

Company Name & Address Date of Injury	
Contact Person & Phone Number	
Policy Number	Effective Date
Workers Compensation Employer Name	
Workers Compensation Employer Address	
Workers Compensation Employer City/State/Zip	
Workers Compensation Employer Phone	

SECONDARY INSURANCE (Medicare supplement or secondary insurance)

Insurance Company Name & Address	
Policy Holder's Name	Relationship to Patient
Policy Number	Group Number
Policy Holder's SS Number	Policy Holder's Date of Birth
Policy Holder's Employer Name	
Phone Number	

THIRD INSURANCE (tertiary)

Insurance Company Name & Address	
Policy Holder's Name	Relationship to Patient
Policy Number	Group Number
Policy Holder's SS Number	Policy Holder's Date of Birth
Policy Holder's Employer Name	
Phone Number	

If Medicare: Are you employed? ____Yes ____No Are you covered by an employer health insurance? ____Yes ____No

HOW DID YOU HEAR ABOUT OUR CLINIC? ______________________________

NAME OF REFERRING DOCTOR: ______________________ ADDRESS: ______________________

NAME OF FAMILY DOCTOR: ______________________ ADDRESS: ______________________

Please complete reverse side.

DES MOINES UNIVERSITY CLINIC

PATIENT ____________________

MR. # ______________ DOB ____________

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.

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

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.

RECORDS RELEASE FOR CLAIMS PAYMENT

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.

Consent to treat 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.

______________________________________ ______________________________________

Patient's signature Date Parent/Guardian's Signature Date

Patient: ______________________________

Email: ______________________________

Date: ____________ DOB: ______________

MRN: ______________________________

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

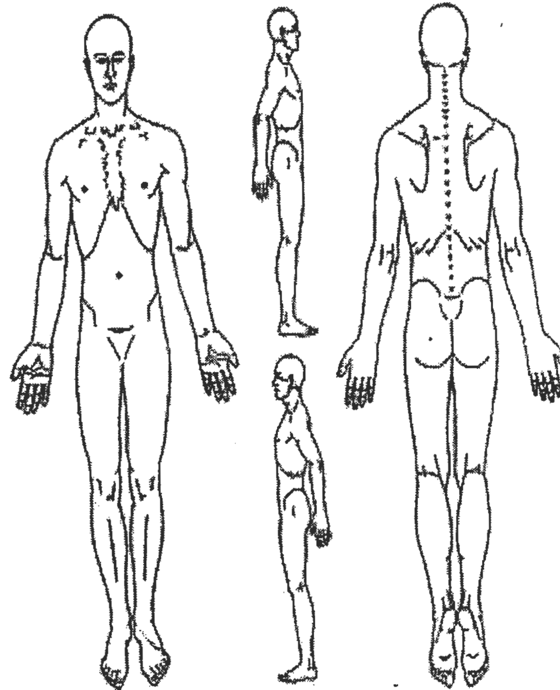
Physical Therapy Intake Report

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

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

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)	



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

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

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

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

____

Patient Signature   Date

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

Communications Request Form

Patient Name (Print): ______________________________ Date of Birth: ________________

Address: ______________________City: ________________ State: _____ Zip: ______

I give permission to be contacted at the following phone number(s) regarding messages, appointments, and/or personal health information for myself, or my minor children, unless restricted by state and/or federal regulations.

Primary phone number: ____________________

Other phone numbers I may be contacted at (different from Primary # above):

Home: ______________________________ OK to leave a message? ☐ Yes ☐ No

Cell: ______________________________ OK to leave a message? ☐ Yes ☐ No

Work: ______________________________ OK to leave a message? ☐ Yes ☐ No

Fax: ______________________________

Other: ______________________________ OK to leave a message? ☐ Yes ☐ No

The following person(s) have my permission to act as my designated health care representative. They may communicate verbally, and in writing, with Des Moines University Clinic staff about my personal health information. *This information may include medical information, financial and insurance information, HIV, drug and alcohol, and/or mental health information.*

Name: ______________________ Phone number: __________________________

Address: ______________________City: ________________ State: _____ Zip: ______

Relationship to patient: ______________

Name: ______________________ Phone number: __________________________

Address: ______________________City: ________________ State: _____ Zip: ______

Relationship to patient: ______________

I hereby authorize Des Moines University Clinic to communicate my personal health information as stated above. *This information may include medical information, financial and insurance information, HIV, drug and alcohol, and/or mental health information.*

Disclaimer: I understand that DMU Clinic cannot guarantee confidentiality of information shared with the person(s) listed above, or when leaving a message at a phone number listed above.

I understand that this permission will be valid until I revoke this in writing.

______________________________ ____________ ______________________________
Signature of patient or legal representative Date Relationship to patient if not signed by patient

To update information Patient is to make changes, as needed, on this form and date and initial			
DATE AND INITIALS	DATE AND INITIALS	DATE AND INITIALS	DATE AND INITIALS

DES MOINES UNIVERSITY
OSTEOPATHIC MEDICAL CENTER
3200 Grand Avenue
Des Moines, IA 50312
(515) 271-1700

WELCOME TO OUR PRACTICE

PATIENT MEDICAL HISTORY

DATE ______

PATIENT: ______

DOB: ______ MR# ______

- **PATIENT SOCIAL HISTORY**

Occupation: ______

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

Caffeine: Never ____ Occasionally (holidays special occasions) ____
# of Cups Per Day ____

Alcohol: Never ____ Occasionally (holidays special occasions) ____
Quit – When ____ / Amount Consumed ______
Current Amount Consumed per Day or Week ______

Tobacco: Never ____ Occasionally ____ Type ______
Quit – When ____ / Amount Used ______
Current Amount Per Day ______

Narcotics: Never ____ Occasionally ____ Type ______
Quit – When ____ / Type & Frequency ______
Current Type & Frequency ______

Exercise: Never ____ Type/Frequency ______

Excessive Exposure At Home or Work To: Noise/type ______
Dust ____ Air-borne particles/type ______
Fumes/type ______ Solvents/type ______

- **PAST SURGERY / HOSPITALIZATION / INJURY** **DATE**

______

______

______

MEDICATIONS – SEE MEDICATION SHEET • ALLERGIES – SEE ALLERGY SHEET • IMMUNIZATIONS – SEE IMMUNIZATION SHEET

- **FAMILY HISTORY** (Include parents, siblings, children, grandparents, spouse)
CHECK ANY ILLNESS/DISEASE OF A FAMILY MEMBER AND LIST WHICH MEMBER/IF DECEASED INDICATE CAUSE

☐ DIABETES ______
☐ BLEEDING TENDENCY ______
☐ HIGH BLOOD PRESSURE ______
☐ KIDNEY DISEASE ______
☐ THYROID ______
☐ STROKE ______
☐ HEREDITARY ILLNESS ______
☐ EYE DISEASE ______
☐ LUNG DISEASE ______
☐ LIVER DISEASE ______
☐ CANCER ______
☐ HEART TROUBLE ______
☐ MENTAL ILLNESS ______

TURN OVER →

PATIENT NAME: ______________________ DOB: ______________ MR# ______________

PATIENT MEDICAL HISTORY AND REVIEW OF SYSTEMS (CHECK ANY PAST OR PRESENT)

- **CONSTITUTIONAL SYMPTOMS**
  - ☐ RECENT WEIGHT CHANGE
  - ☐ CHRONIC FATIGUE
  - ☐ HIGH BLOOD PRESSURE
  - ☐ HIGH CHOLESTEROL
- **EYES**
  - ☐ EYE INJURY
  - ☐ BLURRED / DOUBLE VISION
  - ☐ GLAUCOMA
  - ☐ ITCHY WATTERY EYES
- **EARS/NOSE/MOUTH/THROAT**
  - ☐ SORE THROATS TONSILLITIS
  - ☐ HEARING LOSS
  - ☐ RINGING IN EARS
  - ☐ DRAINAGE FROM EAR
  - ☐ CHRONIC SINUS PROBLEM OR RHINITIS
  - ☐ NOSE BLEEDS
  - ☐ MOUTH SORES/BLEEDING GUMS
  - ☐ HAY FEVER, ENVIRONMENTAL ALLERGIES FOOD ALLERGIES
- **CARDIOVASCULAR**
  - ☐ HEART TROUBLE
  - ☐ CHEST PAIN OR ANGINA PECTORIS
  - ☐ PALPITATION
  - ☐ SHORTNESS OF BREATH – WALKING
  - ☐ SHORTNESS OF BREATH - LYING FLAT
  - ☐ SWELLING OF FEET / HANDS / ANKLES
- **RESPIRATORY**
  - ☐ CHRONIC OR FREQUENT COUGHS
  - ☐ SPITTING UP BLOOD
  - ☐ ASTHMA OR WHEEZING
- **GENITOURINARY**
  - ☐ FREQUENT URINATION
  - ☐ BURNING OR PAINFUL URINATION
  - ☐ BLOOD IN URINE
  - ☐ INCONTINENCE
  - ☐ KIDNEY STONES
  - ☐ SEXUAL DIFFICULTY
  - ☐ MALE – TESTICLE PAIN
    - ☐ PSA
  - ☐ FEMALE – PAIN WITH PERIODS
    - ☐ IRREGULAR PERIODS
    - ☐ VAGINAL DISCHARGE
    - # OF PREGNANCIES ______
    - # OF MISCARRIAGES ______
    - DATE OF LAST PAP SMEAR ______
    - DATE OF LAST MAMMOGRAM ______
- **MUSCULOSKELETAL**
  - ☐ JOINT STIFFNESS/SWELLING
  - ☐ MUSCLE WEAKNESS/PAIN
  - ☐ BACK PAIN
  - ☐ COLD EXTREMITIES
  - ☐ DIFFICULTY WALKING
- **NEUROLOGICAL**
  - ☐ FREQUENT OR RECURRING HEADACHES
  - ☐ LIGHT HEADED OR DIZZY
  - ☐ NUMBNESS OR TINGLING SENSATIONS
  - ☐ TREMORS/PARALYSIS/STROKE/SEIZURES
  - ☐ HEAD INJURY/CONCUSSION
- **GASTROINTESTINAL**
  - ☐ LOSS OF APPETITE
  - ☐ NAUSEA OR VOMITING
  - ☐ CHANGE IN BOWEL HABITS/DIARRHEA/ CONSTIPATION
  - ☐ ABDOMINAL PAIN
  - ☐ RECTAL BLEEDING/BLOOD IN STOOL
  - ☐ PEPTIC ULCER STOMACH/DUODENAL
- **INTEGUMENTARY (SKIN)**
  - ☐ RASH/ITCHING/HIVES
  - ☐ BREAST PAIN/LUMP/DISCHARGE
- **HEMATOLOGY / LYMPHATIC**
  - ☐ SLOW TO HEAL AFTER CUTS
  - ☐ ANEMIA
  - ☐ PHLEBITIS
  - ☐ BLEEDING OR BRUISING TENDENCY
  - ☐ PAST TRANSFUSION
- **ENDOCRINE**
  - ☐ THYROID DISEASE
  - ☐ DIABETES – INSULIN OR NONINSULIN
  - ☐ EXCESSIVE THIRST
- **PSYCHIATRIC**
  - ☐ MEMORY LOSS OR CONFUSION
  - ☐ NERVOUSNESS
  - ☐ DEPRESSION
  - ☐ INSOMNIA
- **FOR CHILDREN ONLY**
  - TERM ______
  - DELIVERY ______
  - BIRTH WEIGHT ______

REVIEWED BY: ______________________________ DATE: ______________

COMMENTS:

Name:________________________________

Date:___/___/_____

FOOT AND ANKLE ABILITY MEASURE (FAAM)

Please answer every question with one response that most closely describes your condition within the past week. If the activity is limited by something other than your foot or ankle mark Not Applicable (N/A).

	No difficulty	Slight difficulty	Moderate difficulty	Extreme difficulty	Unable to do	N/A
Standing	☐	☐	☐	☐	☐	☐
Walking on even ground	☐	☐	☐	☐	☐	☐
Walking on even ground without shoes	☐	☐	☐	☐	☐	☐
Walking up hills	☐	☐	☐	☐	☐	☐
Walking down hills	☐	☐	☐	☐	☐	☐
Going up stairs	☐	☐	☐	☐	☐	☐
Going down stairs	☐	☐	☐	☐	☐	☐
Walking on uneven ground	☐	☐	☐	☐	☐	☐
Stepping up and down curbs	☐	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐	☐
Coming up on your toes	☐	☐	☐	☐	☐	☐
Walking initially	☐	☐	☐	☐	☐	☐
Walking 5 minutes or less	☐	☐	☐	☐	☐	☐
Walking approximately 10 minutes	☐	☐	☐	☐	☐	☐
Walking 15 minutes or greater	☐	☐	☐	☐	☐	☐

Because of your **foot and ankle** how much difficulty do you have with:

	No difficulty	Slight difficulty	Moderate difficulty	Extreme difficulty	Unable to do	N/A
Home responsibilities	☐	☐	☐	☐	☐	☐
Activities of daily living	☐	☐	☐	☐	☐	☐
Personal care	☐	☐	☐	☐	☐	☐
Light to moderate work (standing, walking)	☐	☐	☐	☐	☐	☐
Heavy work (pushing/pulling, climbing, carrying)	☐	☐	☐	☐	☐	☐
Recreational activities	☐	☐	☐	☐	☐	☐

How would you rate your current level of function during your usual activities of daily living from 0 to 100 with 100 being your level of function prior to your foot or ankle problem and 0 being the inability to perform any of your usual daily activities?

☐☐☐.0%

FAAM Sports Scale

Because of your foot and ankle how much difficulty do you have with:

	No difficulty	Slight difficulty	Moderate difficulty	Extreme difficulty	Unable to do	N/A
Running	☐	☐	☐	☐	☐	☐
Jumping	☐	☐	☐	☐	☐	☐
Landing	☐	☐	☐	☐	☐	☐
Starting and stopping quickly	☐	☐	☐	☐	☐	☐
Cutting/lateral movements	☐	☐	☐	☐	☐	☐
Low impact activities	☐	☐	☐	☐	☐	☐
Ability to perform activity with your normal technique	☐	☐	☐	☐	☐	☐
Ability to participate in your desired sport as long as you would like	☐	☐	☐	☐	☐	☐

How would you rate your current level of function during your sports related activities from 0 to 100 with 100 being your level of function prior to your foot or ankle problem and 0 being the inability to perform any of your usual daily activities?

☐☐☐.0%

Overall, how would you rate your current level of function?

☐ Normal ☐ Nearly normal ☐ Abnormal ☐ Severely abnormal