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	Patient Email

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	Language Spoken	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	Patient Work Phone	Patient Cell Phone

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: _____

DMU.CHAR.10A/0512

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

Print Patient Name: _____

Date of Birth: _____

Des Moines University Clinic

3200 Grand Avenue, Des Moines, IA 50312

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of the Des Moines University Clinics, effective date April 14, 2003.

_____ _____

Signature of Patient or Legal Representative Date

Patient Consent Form

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting a written request to the Health Information Manager, Des Moines University Clinic, 3200 Grand Avenue, Des Moines, Iowa 50312.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____ _____

Signature of Patient or Legal Representative Date

Des Moines University
3200 Grand Avenue
Des Moines, IA 50312
Phone (515) 271-1700

Permission for Verbal Communications to Others About My Health Information

I give permission to use and/or disclose my health information as described below. I understand that if the individual or organization, listed below, is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken on it, by giving written notice to Des Moines University (DMU) at the address listed above. I understand that I have the right to discuss/inspect the information to be disclosed by notifying DMU at the address listed above and following the procedures established by DMU.

_____ _____
Print Patient Name Date of Birth

_____ _____
Address City, State, Zip

The purpose of this authorization is for me to give my permission to allow the family members or friends, listed below, to verbally discuss my health and/or financial/insurance information related to my care at DMU.

List the family member(s) / friend(s) and the person's relationship to the patient.

	NAME	PHONE NUMBER	RELATIONSHIP
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of information relating to: (check all that apply)
Any item not checked – will not be discussed.

- ☐ Mental Health
- ☐ HIV-related information (including AIDS and related testing)
- ☐ Substance abuse treatment (Alcohol / Drug)

The following condition(s) / issue(s), listed below, will not be discussed with the individuals listed on this form:

_____

_____

Release of information under this permission form is limited to verbal discussions only with DMU. This document does not permit the release of any written health information to the individuals named above. I understand that DMU cannot guarantee confidentiality of information shared with the individual(s) listed above.

_____ _____
Patient or legal representative signature **Date**

Prohibition on Redisclosure

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug treatment records or by state law for mental health records, federal requirements (42 CFR, Part2) and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and /or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse treatment or mental health information

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?

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)

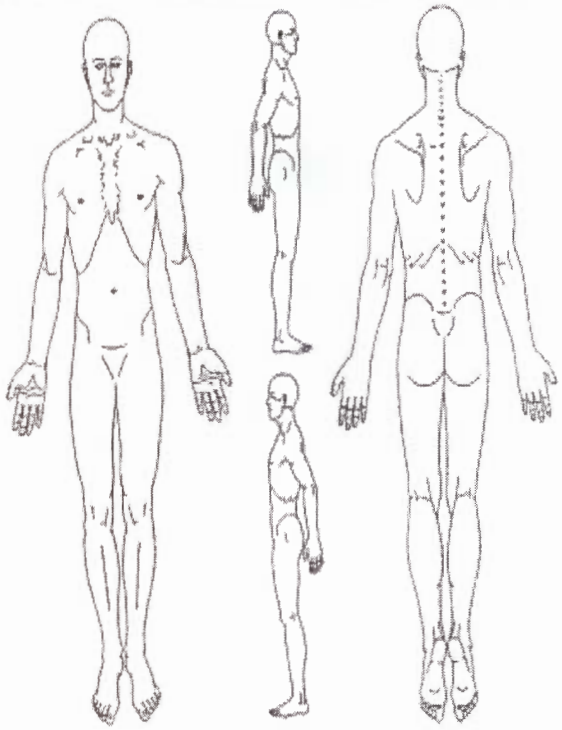
Medications:
(write "none" if none)

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					

DES MOINES UNIVERSITY

Welcome to our practice!!

Family History

Family Member	Age if Living	Age Deceased	Cause of Death
Mother			
Father			
Maternal Grandmother Paternal			
Maternal Grandfather Paternal			
Sibling			
Children			

FPHx02/09

Use the key to indicate if any of your family members currently have or have had any of the conditions/diseases listed.

M=Mother F=Father B=Brother
S=Sister G=Grandparent

DISEASE/COND.	M	F	B	S	G
Alcoholism					
AIDS					
Alzheimer's					
Anemia					
Anesthesia Problems					
Anxiety					
Asthma					
Bleeding Disorders					
Blood Clots					
Cancer					
Type:					
Depression					
Diabetes					
Emphysema					
Glaucoma					
Heart Disease					
Hemorrhoids					
High Cholesterol					
High Blood Pressure					
Kidney Disease					
Migraines					
Osteoporosis					
Seizures					
Stroke					
Thyroid Disease					
Tuberculosis (TB)					

Additional Comments on Family History:_____

_____

LOWER EXTREMITY FUNCTIONAL SCALE[1]

Section 1: To be completed by patient _____AD _____Non-Active Duty

Name: _____ Age:_____ Date:_____

Occupation:_____ Onset of knee pain:_____(this episode)

Section 2: To be completed by patient

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today do you, or would you have difficulty at all with: (Circle one number on each line)

	Extreme Difficulty or Unable to Perform Activity	Quite a bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS:					

Section 3: To be completed by physical therapist/provider

SCORE:_____ out of 80 (No Disability 80, SEM 5, MDC 9) **Initial** **FU ___ weeks** **Discharge**

Number of treatment sessions:_____ **Gender:** Male Female

Diagnosis/ICD-9 Code:_____

[1] adapted from Binkley J et al; Phys Ther; 79: 371-383, 1999.[Prepared Feb 01]