VALLEY PHYSICAL THERAPY
1711 Dalles Military Road, Walla Walla, WA 99362
Phone 509-529-3220, Fax 888-828-3016
DAVID TUPPER, RPT

Name_____ Today's Date_____

Date of birth_____ Gender: □ Male □ Female □ Other □ Prefer not to disclose

Address_____

City_____ State_____ Zip_____

Phone: Home_____ Mobile_____ Work_____
I consent for Valley Physical Therapy to send text (SMS) appointment reminder messages to my mobile telephone number □ Yes □ No

OR

I would prefer an Email appointment reminder to the following email address_____

Insurance Information

Primary Insurance_____ ID#_____ Group #_____

Secondary Insurance_____ ID#_____ Group #_____

Work related injury? □ Yes □ No Date of injury_____ Claim #_____

Auto Accident? □ Yes □ No Date of accident_____ Claim #_____

Is an attorney involved in this case? □ Yes □ No

Acknowledgement of Receipt of Privacy Practices:

I have received a copy of Valley Physical Therapy's notice of Privacy Practices. I understand that I have the right to refuse to sign the acknowledgment if I so choose.

Valley Physical Therapy can discuss all aspects of my care with:

Contact Name:_____ Relationship:_____

Contact Name:_____ Relationship:_____

Initial_____

I authorize Valley Physical Therapy to render physical therapy services to myself or person to whom I am legal guardian. I understand I am financially responsible for any balance. I also authorize Valley Physical Therapy or my Insurance Company to release any information required to process my claims. I have read and understand all of the above information. The information is true and correct to the best of my knowledge.

Signed for myself and dependents: _____Date_____

(over)

Medical History

Name:_____ Referring Physician:_____

Family Physician:_____ Height_____ Weight_____

Are you currently taking any prescription or non-prescription medication? □ Yes □ No

Anti-inflammatory: □ Muscle Relaxers: □ Pain Meds: □

List:_____

Are you allergic to any medications? □ Yes □ No If yes, Please List:_____

Have you had any of the following medical or rehabilitative services for this injury/episode? Please check:

□ Chiropractor
□ Massage Therapy
□ Occupation Therapy
□ ER Care
□ General Practitioner
□ Neurologist
□ Podiatrist
□ Other:_____

□ Orthopedist
□ Myelogram
□ Physical Therapy
□ CT Scan
□ MRI
□ X-Rays
□ EMG/NCV

Do you have or have you ever had any of the following? Mark the box to indicate Yes

□ Asthma, Bronchitis, or Emphysema	□ Severe/Frequent Headaches
□ Shortness of Breath/Chest Pain	□ Vision or Hearing Problems
□ Coronary Heart Disease or Angina	□ Numbness or Tingling
□ Sleeping Problems/difficulty	□ Dizziness or Fainting
□ High Blood Pressure	□ Bowel or Bladder Problems
□ Heart Attack or Surgery	□ Weakness
□ Stroke/TIA	□ Weight Loss or Energy Loss
□ Congestive Heart Disease	□ Hernia
□ Blood Clot or Emboli	□ Varicose Veins
□ Epilepsy/Seizures	□ Do you use tobacco
□ Thyroid Disease or Goiter	□ Any pins or metal implants
□ Anemia	□ Joint replacement surgery
□ Infectious Disease	□ Neck injury/surgery
□ Diabetes	□ Shoulder injury/surgery
□Cancer or Chemo/Radiation	□ Elbow/hand injury/surgery
□ Arthritis	□ Back injury/surgery
□ Osteoporosis	□ Knee injury/surgery
□ Gout	□ Leg/ankle/foot injury/surgery

Are you aware of your diagnosis & prognosis as explained by your doctor? □ Yes □ No

Do you have a pacemaker? □ Yes □ No Are you pregnant? □ Yes □ No

Have you had any falls in the last year □ Yes □ No

Do you have any severe allergies (i.e. latex, oils, perfumes etc) □ Yes □ No if yes list:_____

In the past month have you been bothered by:

feeling down, depressed or hopeless □ Yes □ No or, had little interest or pleasure in doing things? □ Yes □ No

What are your rehabilitation expectations/goals while in physical therapy?

_____