Outpatient Therapies

La Posada Out-Patient Therapies

700 S. La Posada Circle
Green Valley, AZ 85614
(520)648-2200

Therapist: ______________________

Evaluation Date: ________________

Time: __________________________

PLEASE ARRIVE 15 MIN. EARLY FOR CHECK IN

(PLEASE PRINT)

Patient Name: ____ Patient Social #: ________________________________

Gender: [_] Male [_] Female Birth Date: _______________________Age: _______Marital Status: ___________________

Mailing Address / City, State, Zip: ____

Alternate Address/ City, State, Zip: ____

Home Phone: (_____) ________________ Other: (_____) ____________ Email: __________________________________

Parent/Guardian: __________________________________ Relationship to Patient: ____________________________

Primary Physician: ________________________________ Referring Physician: ________________________________

Employment Status: _______________________________ Student: ____

Emergency Contact: _______________________________ Relationship/Phone: ________________________________

Primary Insurance Name: _______________________ Secondary Insurance Name: ___________________________

***If your medical insurance requires a co-payment, it must be paid upon check-in for each appointment. We accept Cash, Checks, and Visa or MasterCard.**

AUTHORIZATION TO RELEASE PATIENT INFORMATION: I hereby authorize La Posada Out-Patient Therapies to release any personal health information (PHI) required in the course of my examination or treatment to the above stated insurance company, or their affiliates.

Signed (Patient or guardian) ____ Date________________

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to La Posada Out Patient Therapies, for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance(s). In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or Guardian) ____ Date________________

___ I certify I have received a copy of La Posada Therapies Privacy Notice and Rights and Responsibilities. I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanation provided to me and I am confident that La Posada Out-Patient Therapy is committed to protecting my health information.

Signature of Witness____ Date________________

Who can we thank for this referral?

__ Friend __ Doctor __ Advertisement __ Other _________________

Outpatient Therapies

Name: ____ DOB: ____

Chief complaint: ____

Onset date of symptoms: _____________ How did you injure yourself? ____

Any surgeries and dates: ____
____

Please **list** or **provide** written copy current medications (Include Supplements, skin patches, or Injections):__________________________
____

Diagnostic tests: X-Ray: ____MRI: ___CT: ___EMG: ___Doppler/Ultrasound: ___ Bone Density: ___Other: __________________________

Name of your Primary Care Practitioner (if different from who referred you to therapy): ________________________________
Have you had prior outpatient therapy or Home Health during this current calendar year? **YES** **NO**
If yes, list approx. dates: _____________________________

DO YOU CURRENTLY HAVE OR DO YOU HAVE A HISTORY OF ANY OF THE CONDITIONS LISTED BELOW? PLEASE CHECK/CIRCLE ALL THAT APPLY											
	Yes	**No**		**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Cancer Type:			**Thyroid Problems**			**Respiratory/Lung Problem**			**Skin Disorder/Rashes**		
Diabetes Type: I or II			**Myofascial Pain Syndrome**			**Cardiovascular Disease**			**Infectious Disease/MRSA**		
Parkinson's			**Fibromyalgia**			**Pacemaker**			**Osteoarthritis/Gout**		
Liver Problems			**Depression/Anxiety**			**Hypertension/ High BP**			**Rheumatoid Arthritis**		
Hepatitis/Jaundice			**Neurologic Disease**			**Blood Clots/DVT**			**Osteoporosis/Osteopenia**		
Stomach Problems/ Ulcer			**Head Injury/ Concussion**			**Rheumatic/Scarlet Fever**			**Broken Bones/Fracture**		
Bowel/Bladder Problems			**Epilepsy/Seizures**			**Tuberculosis**			**Dislocations**		
Kidney Problems			**Stroke/TIA**			**Wounds Open/Closed**			**Other:**		
Smoker/Tobacco Use			**Learning Barriers**			**Blood Disorders**			**Exercise Regularly/ Healthy Diet**		
Hearing Problems			**Hearing Aids**			**Vision Problems**			**Reading Glasses**		
			Aids Help?						**Distance Glasses**		
Difficulty Swallowing			**Unplanned Weight Loss**			**Poor Appetite**			**Voice Problems**		
Trouble Speaking			**Memory Problems**			**Difficulty Reading**			**Difficulty Writing**		

Please list allergies and known adverse drug reactions: ____

Have you had any falls in the past 12 months? **YES** **NO** If so, How many? ______ Did your fall(s) result in injury? **YES** **NO**

If you have fallen in the past year, what caused your fall(s)? ____

Prior Functional Status: Independent Assistance Needed Totally Dependent

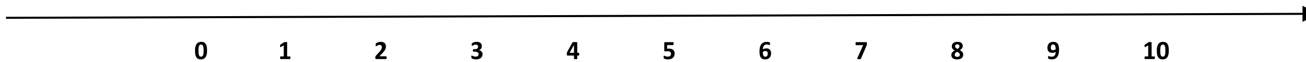
Home: Number of steps into home ______ Stairs ______ Number of people living at home with you? ______

Assistive Devices: Cane Walker Crutches Wheelchair Shower Chair Elevated Toilet Grab Bars

Outpatient Therapies

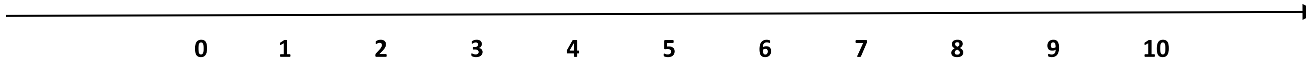
Name: ____ DOB: ____

Rate your **CURRENT** pain level on a scale of 0 to 10 (**0 is no pain and 10 is the worst pain you can imagine**)



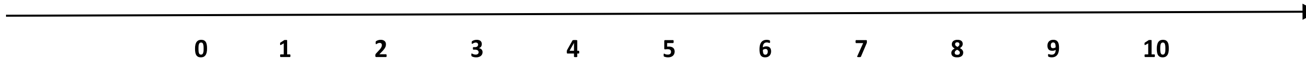
0 1 2 3 4 5 6 7 8 9 10

Rate your pain level at **BEST** on a scale of 0 to 10 (**0 is no pain and 10 is the worst pain you can imagine**)



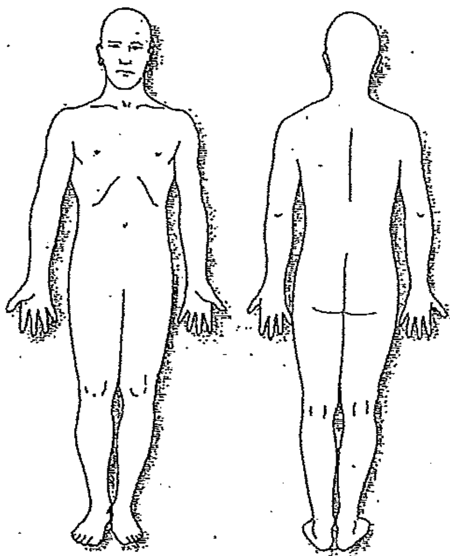
0 1 2 3 4 5 6 7 8 9 10

Rate your pain level at **WORST** on a scale of 0 to 10 (**0 is no pain and 10 is the worst pain you can imagine**)



0 1 2 3 4 5 6 7 8 9 10

Indicate the symptom location on the diagram.



Please circle your symptoms: ______________________________

Sharp	Dull/Ache
Electric	Hot/Burning
Numbness	Tingling
Cramping	Tightness
Radiating	

Other: _________________________

My symptoms are made worse by:	**My symptoms are made better by:**
Walking/Activity	Rest
Sleeping	Activity
Sitting	Standing
Standing	Lying Down
Work Duties	Sitting
Turning/Twisting	Heat
Reaching	Cold
Bending	Medication
Gripping/Grasp	Massage
Stress	Brace/Assistive Device

Since the onset of your symptoms, have you had (circle all that apply)?

Unusual fatigue	Fever/Chills	Nausea/Vomiting	Waking pain at night
Dizziness/Fainting	Unusual Weight loss/gain	Diarrhea	Other

Please list your two (2) primary goals for therapy:

1.____ **2.** ____

In case of unforeseen circumstance, please attempt to notify La Posada Outpatient Therapies department 24 hours in advance. Repeated cancellations or not showing up for scheduled therapy sessions may result in discontinuation of services. It is the department's policy that three late/cancellations/no shows within a thirty-day period may result in your discharge from therapy. If you do not present to the clinic for three consecutive, scheduled visits without notification, you will be discharged back to the care of your physician.

I have read, understand, and agree to the above stated policy. ____ Date: _________________

Patient/Guardian Signature