Outpatient Therapies

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

PLEASE ARRIVE 15 MINUTES EARLY FOR CHECK IN

Therapist: _____
Evaluation Date: _____
Time: _____

(PLEASE PRINT)
Patient Name: _____ Social Security Number: _____

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: _____

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 Outpatient 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.

Signature (Patient or guardian) _____ Date_____

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to La Posada Outpatient 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.

Signature (Patient or Guardian) _____ Date_____

___ I certify I have received a copy of La Posada Outpatient 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 Outpatient Therapies is committed to protecting my health information.

Signature of Witness_____ Date_____

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Name: _____ DOB: _____

Chief complaint: _____

Onset date of symptoms: _____ Date of surgery: _____

How did you injure yourself? / How did your problem start? _____

Is your injury related to? ____Work ____Car Accident ____Not Applicable

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

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

1._____ **2. _____**

Have you had prior Outpatient Physical, Occupational or Speech therapy or Home Health Therapy during this 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 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)? _____

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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

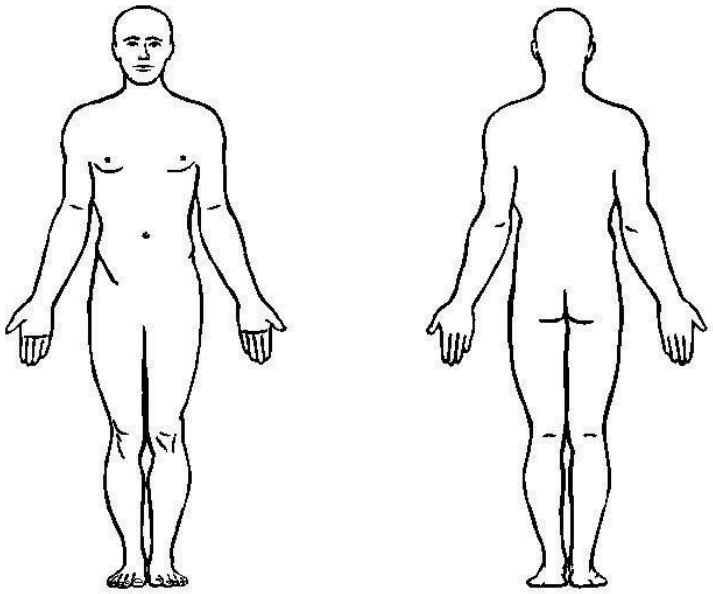
Rate your pain level at **BEST** on a scale of 0 to 10 (**0 is no pain and 10 is the worst pain you can imagine**)

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

Please mark the location of your pain on the diagram.



Please circle your symptoms:

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

Other: _____

My symptoms are made better by: _____
_____

My symptoms are made worse by: _____
_____

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