# Whitefish Therapy & Sport Center

## Patient Information Form

***Patient Information***

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

***Emergency Contact***

Last Name _____ Relationship _____

First Name _____ Phone _____

***Employer***

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

***Problem***

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____ Primary Care Physician _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

***Primary Insurance***

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

*Subscriber*

Name _____

Relationship _____

Date of Birth _____

***Secondary Insurance***

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

*Subscriber*

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. Contact Ashley McGuire @ 406-862-9378.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

**PQRS Health Questionnaire – OT, ST & Multi-Discipline**

Patient Name:_____ Date:_____

**Section 1, Medications:**

Please list your current medications, including: ***over the counter medications, vitamins/mineral/dietary supplements, prescription medications and any herbal supplements:***

**For each medication, please list the following:**

| | Name of Medication/ Vitamin/Herbal Supplement | Dosage | Frequency | Route of Administration* |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |

*(Definition of route of administration: oral, subcutaneous, IV, etc.)

If more space is needed, continue on back of page.

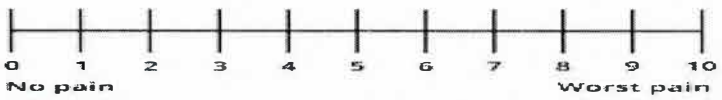
**Section 2, Pain:**

Do you have pain: Yes_____ No_____

If yes, please list where:_____

Using the pain scale below, please rate the amount of pain you have right now:_____

Using the pain scale below, please rate your pain when it is at it's worst:_____




Rate your pain or pain relief from 0-10

_____ I have completed this to the best of my knowledge
(Patient/Parent/Guardian's initials)

_____ Read and Reviewed
(Therapist's Initials)

**Section 3, Falls:**

Have you had 2 or more falls in the past 12 months? Yes_____ No_____

If yes, how many falls have you experienced in the past 12 months?_____

Have you had a fall that resulted in an injury in the past 12 months? Yes____ No_____

If yes, what kind of fall did you suffer and what was the subsequent injury?_____

_____

**Section 4, Smoking:**

Do you currently use tobacco or tobacco products? Yes_____ No_____

If yes, what type and how frequently:_____

**Section 5, Alcohol Use:**

How many times in the last year have you had 4 or more drinks?_____

**Section 6, EASI:**

| | | | |
|---|---|---|---|
| 1.) Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals? | Yes | No | |
| 2.) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides, or medical care, or from being with people you wanted to be with? | Yes | No | |
| 3.) Have you been upset because someone talked to you in a way that made you feel shamed or threatened? | Yes | No | |
| 4.) Has anyone tried to force to you sign papers or to use your money against your will? | Yes | No | |
| 5.) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? | Yes | No | |

**Medications, continued from front page:**

| | Name of Medication/ Vitamin/Herbal Supplement | Dosage | Frequency | Route of Administration* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

_____ I have completed this to the best of my knowledge
(Patient/Parent/Guardian's initials)

_____ Read and Reviewed
(Therapist's Initials)

**Health History Attachment:**

Are you currently receiving services from Home Health providers (either nursing or therapy)? ___Yes ___No

Have you had a complete medical check-up in the last year? ___Yes ___No

Do you now have or have you recently had any of the following complaints:

- ☐ Pain or a feeling of heaviness in your chest
- ☐ Pulsating pain anywhere in your body
- ☐ Constant and severe pain in lower leg (calf)
- ☐ Frequent or severe abdominal pain
- ☐ Persistent pain at night
- ☐ Unexplained weight loss (10-15 lbs in 2 weeks)
- ☐ Unusual lumps or growths

Do you currently have or have you ever had any of the following medical conditions?

| | | | |
|---|---|---|---|
| ___Asthma | ___Bronchitis | ___Diabetes | ___Hernia |
| ___Heart Disease | ___Chest Pain | ___ Epilepsy | ___Tuberculosis |
| ___ Epilepsy | ___Arthritis | ___ High Blood Pressure | |
| ___Cancer | ___ HIV/AIDS | ___Low Blood Pressure | |
| ___Sickle Cell Anemia | | ___Other:_____ | |

_____ I have completed this to the best of my knowledge
(Patient/Parent/Guardian's initials)

_____ Read and Reviewed
(Therapist's Initials)

**Would you like to receive a text or email reminder:** ☐ YES ☐ NO

Cell phone: _____

Cell phone provider : _____

Email: _____

** This service will send you a reminder the day before your appointment**

**If patient is a minor:**

Mother's Name: _____

Address: _____

_____

Phone: _____

DOB: _____

Social Security Number: _____

Father's Name: _____

Address: _____

_____

Phone: _____

DOB: _____

Social Security Number: _____

Parent(s) Printed Name: _____

Parent(s) Signature _____

Date: _____