OUTPATIENT THERAPY CENTER

8656 West Patrick Lane, Las Vegas, NV 89148
Main # (702) 777-7171 Fax # (702) 777-7170

PATIENT INFORMATION

Name______________________________ Social Security____________

Date of birth________________ Age _____ ❑Male ❑Female

Street Address ______________________________ Apt. # ________

City/State/Zip ______________________________

Cell Phone # ______________ Home Phone # ______________

❑ Married ❑ Single ❑ Widowed ❑ Divorced

Email______________________________

Employer______________ Title __________ Phone # ________

Emergency contact ______________ Relationship__________

Phone # ______________________________

Appointment reminder preference: ❑ Email ❑ Phone Call ❑ Text Message ❑ No Reminder

Would you like to sign up for patient portal for records: ❑ Yes ❑ No

PRIMARY INSURANCE INFORMATION

Insurance Company Name:______________ Phone # __________

Responsible Party Name______________ Relationship__________

Date of birth______________ Social Security______________

Employer______________ Phone # __________ Ext.______

Title______________ Retirement Date __________

Member # ______________ Group # ______________

SECONDARY INSURANCE INFORMATION

Insurance Company Name:______________ Phone # __________

Responsible Party Name______________ Relationship__________

Date of birth______________ Social Security______________

Employer______________ Title ______________

Member # ______________ Group # ______________

PHYSICIAN INFORMATION

Referring__________ Primary Care__________ Surgeon__________

BAR CODE

HP1023

Valley Health
SURGERY *and* REHAB HOSPITAL
A Member of The Valley Health System

PATIENT HISTORY

(PMM# 55846) (R 1/22) (FOD)

PATIENT IDENTIFICATION

HEALTH HISTORY

What can you therapist help you achieve?

____

Do you have difficulty with: *(check all that apply)*

□Communication □Vision □None

□Speech □Hearing □Other: __________

How is your general health? *(Circle most appropriate)*

Poor Fair Good Very Good Excellent

Have you or any immediate family members have
(Circle yes or no)

	Self		Family	
Cancer	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Heart Attack	Yes	No	Yes	No
Stroke/TIA	Yes	No	Yes	No
Rheumatoid Arthritis	Yes	No	Yes	No
COPD	Yes	No	Yes	No

Do you have a history of: *(Circle Yes or No)*

Unusual fatigue	Yes	No
Unexplained weakness	Yes	No
Nausea/Vomiting	Yes	No
Fever/Chills/Sweats	Yes	No
Unexplained weight change >10lbs	Yes	No
Numbness or tingling	Yes	No
Changes in appetite	Yes	No
Difficulty swallowing	Yes	No
Changes in cough	Yes	No
Shortness of breathe	Yes	No
Changes in hearing or hearing loss	Yes	No
Bowel changes (pain, blood, control)	Yes	No
Bladder changes (pain, blood, control)	Yes	No
Infection or antibiotic use	Yes	No
Unexplained falls/decreased balance	Yes	No
Dizziness/lightheadedness	Yes	No
Changes in vision	Yes	No
Pneumonia	Yes	No

Are you:

Pregnant/ potential pregnant/ nursing	N/A	Yes	No
Often bothered by feeling down, depressed or hopeless		Yes	No

Do you: (Circle Yes or No)

Feel safe at home?	Yes	No
Use tobacco (smoke/dip/chew/vape)?	Yes	No
If yes: ________ per day/week, For ___ years		
Use Alcohol:	Yes	No
If Yes: __________ drinks per week		
Use caffeine?	Yes	No
If yes: ________ drinks per day		
How many hours of sleep do you get per night?		

List any Medications/supplements you are taking:

□None ___________________________________

____

____

List any drug or latex allergy? □ None

____

____

In the past 3 months have you experienced: *(Circle Yes or No)*

Asthma/Bronchitis	Yes	No
Heart/Chest pain/Angina	Yes	No
Covid 19	Yes	No
Easy or excessive bruising/bleeding?	Yes	No
Heart Disease	Yes	No
Heart Afib	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Migraines	Yes	No
Neurological disease	Yes	No
Osteoarthritis	Yes	No
Osteoporosis	Yes	No
Seizures	Yes	No
Sexually transmitted disease	Yes	No

HEALTH HISTORY

List 2 activities you have difficulty doing because of your pain. Then on the scale below each activity, mark how difficult the activity is to perform. (Example: Running 1 mile - 8)

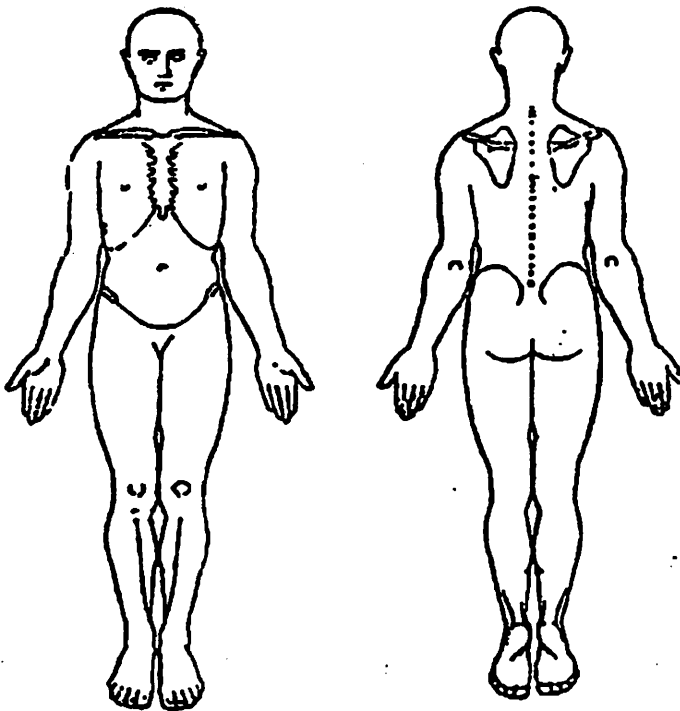
Activity #1: ____

0	1	2	3	4	5	6	7	8	9	10
No restrictions				Moderate difficulty				Unable to perform		

Activity #2: ____

0	1	2	3	4	5	6	7	8	9	10
No restrictions				Moderate difficulty				Unable to perform		

Mark on the body chart the location of your problem(s)



Rate your LOWEST pain level in the last 72 hours

0	1	2	3	4	5	6	7	8	9	10
No pain								Worst		Pain

Rate your HIGHEST Pain level in the last 72 hours

0	1	2	3	4	5	6	7	8	9	10
No pain								Worst		Pain

Balance:

Have you fallen in the last 6 months: ☐NO ☐YES-How many time: _______

Have you decreased your activity level because of a fear of falling? ☐NO ☐YES

Are you reluctant to leave your home because of a fear of falling? ☐NO ☐YES

Please provide other information you believe will be helpful in the development of your care with us at Valley Health Specially Hospital Outpatient Therapy Center:

Patient Signature Date

BAR CODE

AS1461

Valley Health
SURGERY *and* REHAB HOSPITAL
A Member of The Valley Health System

HEALTH HISTORY
(PMM# 55889) (R 7/22) (FOD)

PATIENT IDENTIFICATION

WELCOME TO OUTPATIENT THERAPY SERVICES AT VALLEY HEALTH SPECIALTY HOSPITAL

Dear Patient,

Welcome to Outpatient Therapy Services at Valley Health Specialty Hospital. In order for us to provide you with the highest possible quality of care, we ask for your full cooperation with the following:

- CANCELLATIONS AND NO SHOWS

  If you are unable to keep a scheduled appointment, please notify us at least 24 hours in advance. We will make every attempt to reschedule your appointment. If cancellation or no shows become excessive (3 maximum), we will take you off the schedule and ask you to call us the morning of the day you wish to be seen. We will try our best to fit you into the schedule at the time you have requested.

  All cancellations and no shows are documented in your medical chart. Referring Physicians for worker's compensation patients are notified after each missed and or no show appointments.

- COPAYMENTS/CO-INSURANCE

  If you are not covered 100% by your primary insurance provider, you will have a co-payment or co-insurance portion due. You are expected to make your payment at each visit.

Our Center runs on a schedule and our therapists give the highest quality of care in a timely fashion. Please make every effort to be on time for your appointment. If you have business at the front desk, such as making a co-payment or scheduling, please arrive early enough to do so in a timely manner.

Cordially,

Outpatient Therapy Center Staff

Patient Signature	Print Name	Date

BAR CODE	Valley Health SURGERY and REHAB HOSPITAL A Member of The Valley Health System WELCOME TO OUTPATIENT THERAPY SERVICES AT VALLEY HEALTH SPECIALTY HOSPITAL (PMM# 55847) (R 7/21) (FOD)	PATIENT IDENTIFICATION
 ED0010 - Education		