DEL VALLE
PHYSICAL THERAPY & HAND THERAPY

We are pleased to welcome you to our clinic and thank you for choosing us for your therapy needs. This form is used to collect information for internal purposes only. The information will remain confidential and privileged.
Please answer all questions fully and accurately to the best of your knowledge.

CASE FORM (Please Print)

Full Name:_____DOB: _____Age: _____

Address: _____

Health Insurance Information

Primary Insurance: _____
Subscriber Name: _____ DOB: _____
Policy Number: _____Group: _____
Relationship to Insured: _____

Secondary Insurance: _____
Subscriber Name: _____ DOB: _____
Policy Number: _____Group: _____
Relationship to Insured: _____

Medical Information for this episode of care

Referring Physician: _____ Surgeon or Primary Care Physician: _____

Are you scheduled for a follow up with your doctor? ☐ NO ☐ YES Date of follow up: _____

What part of your body will we be treating? _____

Briefly explain how your injury occurred: _____

When did your pain begin or become worse? _____

Have you had diagnostic test(s) completed? ☐ MRI ☐ X-Ray If yes, where:_____

Are you currently employed? ☐ NO ☐ YES What is your occupation? _____

Is this injury related to: ☐ Employment ☐ Automobile Accident ☐ Worker's Compensation ☐ None

Has your injury restricted your employment? ☐ NO ☐ YES Are you off work due to this injury? ☐ NO ☐ YES

Rate your health at the present time: Excellent Very Good Fair Poor

Have you fallen 2 or more times this year? ☐ NO ☐ YES

Have you had any falls with injuries in the past year? ☐ NO ☐ YES

Have you used any tobacco products in the last 24 months? ☐ NO ☐ YES

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*Are you currently receiving health -related services at your home (Home Health Aide)? ☐ NO ☐ YES
If yes, with what agency: _____

*Have you received any physical or occupational therapy in the past 60 Days? This includes hospital, rehab, nursing home, or in home? ☐ NO ☐ YES

*Where do you live (or intend to live) concluding this therapy episode?
☐ Private Home ☐ Private Apartment ☐ Rented Room ☐ Group Home ☐ Board & Care Apartment
☐ Assisted Living ☐ Skilled Nursing Facility ☐ Other: _____

*Who do you live with (or intend to live with) at the conclusion of this outpatient therapy episode?
☐ Live Alone ☐ Spouse/Significant other ☐ Child/Children ☐ Other Relative ☐ Unrelated Person(s)
☐ Personal Care Attendant ☐ Other: _____