Confidential Patient Information

Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Home #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Email**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City**\_\_\_\_\_\_\_\_\_\_\_**State**\_\_\_\_\_\_\_**Zip Code**\_\_\_\_\_\_\_\_\_\_**

Age**\_\_\_\_\_\_\_\_** Birth Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Marital**: M S W D** How Many Children? **\_\_\_\_\_\_\_**

Height**\_\_\_\_\_\_**Weight**\_\_\_\_\_\_\_**Occupation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Employer**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**Office Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Insured name if patient is a dependent**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Insurance Company**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Husband/Wife**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patients nearest relative**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_**Phone# **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is condition a work related accident? \_\_\_\_YES \_\_\_\_NO Date symptoms appeared or accident occurred\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient ever had same or similar condition **\_\_\_YES \_\_\_NO** If Yes, when and

describe**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_**

Have you lost any days from work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Female: Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What operations have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Serious Illness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HAVE YOU EVER SUFFERED FROM: Check all that apply**

**\_\_\_**Allergy \_\_\_Foot Trouble \_\_\_Sinus Infection \_\_\_Headache \_\_\_Dizziness

\_\_\_Fatigue \_\_\_Low Back Pain \_\_\_High Blood Pressure \_\_\_Poor Posture \_\_\_Fatigue

\_\_\_Neck Pain \_\_\_Low Blood Pressure \_\_\_Poor Circulation \_\_\_Loss of Sleep \_\_\_Sciatica

\_\_\_Rapid Heart Beat \_\_\_Ulcers \_\_\_Arthritis \_\_\_Asthma \_\_\_Difficulty Breathing

\_\_\_Spinal Curvature \_\_\_Bursitis \_\_\_Ear Noises \_\_\_Varicose Veins \_\_\_Slow Heart Beat

\_\_\_Enlarged Thyroid \_\_\_Kidney Infection or Stone \_\_\_Depression \_\_\_Eye Pain \_\_\_Prostate Trouble

\_\_\_Swollen Joints \_\_\_Failing Vision \_\_\_Irregular Cycle \_\_\_Stroke \_\_\_Venereal Disease

\_\_\_Colon Trouble \_\_\_Tuberculosis \_\_\_Diabetes \_\_\_Chest Pain

**Tingling or numbness in: Check all that apply**

\_\_\_\_Shoulders \_\_\_\_Hips \_\_\_Arms \_\_\_\_Legs \_\_\_\_Elbows \_\_\_\_Knees \_\_\_\_Hands

**Additional Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please Print Clearly**

Purpose of this appointment (Major Complaint)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What activities aggravate your condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_ Yes \_\_\_\_ No \_\_\_ Constant \_\_\_\_ Comes & Goes

Is this condition interfering with your work? \_\_\_\_ Work \_\_\_\_ Daily Routine \_\_\_\_ Sleep \_\_\_\_ Other

How long has it been since it really felt good? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen other Doctors for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for any health conditions by a physician in the last year? \_\_\_\_ Yes \_\_\_ No Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you insured? Yes No

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_ POS PPO HMO EPO

Is there an FSA/HSA Account attached to this card? \_\_\_\_\_ Yes \_\_\_\_\_No

Do you have a secondary insurance? Yes No

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_ POS PPO HMO EPO

 I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports or forms to assist me making collections from the insurance company and then any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered are to be charged to directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

In accordance with Education Law section 6731(d), a physical therapist providing treatment in the practice of physical therapy without a referral from a physician, dentist, podiatrist, or nurse practitioner, in accordance with Education Law section 6731(d) and the requirements of this section shall advise the patient in writing prior to beginning treatment of the possibility that treatment may not be covered by the patient’s health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner and that treatment may be a covered expense if rendered pursuant to such referral. **For your convenience we have a medical doctor on staff that can evaluate you and prescribe physical therapy if necessary.**

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian or Spouse’s Signature Authorizing Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_