NY Physical Therapy & Wellness
Friendly • Professional • Dedicated

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE
PLEASE ANSWER ALL QUESTIONS

PATIENT INFORMATION					
Full Name:					
Address:			**Contact Information (please check off BEST CONTACT)**		
			☐ Home:		
			☐ Cell:		
			☐ E-Mail:		
Birth Date	**Age**	**SSN**	**Sex**	**Marital Status**	
			☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed	

HOW DID YOU HEAR ABOUT US?

☐ Former Patient ☐ Walk In ☐ Insurance Co ☐ www.nyphysicaltherapy.net ☐ PhysicalTherapist.com
☐ Advertisement ☐ Patient Referral:_____ ☐ Doctor: _____
☐ Website: _____ ☐ Other: _____

WORK INFORMATION		
Employer:	Work Phone:	Ext:
Address:	**Employment Status**	
	☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Doctor:	Regular Dr. / PCP:
Phone Number:	Phone Number:

INSURANCE INFORMATION (Please give your insurance card(s) to the Receptionist)	
Primary Plan Name:	Secondary Plan Name:
Subscriber Name:	Subscriber Name:
Member ID#:	Member ID#:
DOB:	DOB:
Relationship to Subscriber	**Relationship to Subscriber**
☐ Spouse ☐ Self ☐ Child ☐ Other:	☐ Spouse ☐ Self ☐ Child ☐ Other:

AUTO OR WORK INJURY CLAIM (Please provide your sinruance information above for backup)	
Insurance Name:	**Injury Resulted From**
Address:	☐ Auto ☐ Work / Labor ☐ Slip & Fall
	Adjuster/Claim Rep:
	Phone #:
Claim #:	Date of Accident:

ATTORNEY INFORMATION	
Name:	Law Firm Office:
Address:	Phone Number:
	Fax Number:

IN CASE OF EMERGENCY	
Name of Local Friend of Relative:	Home Phone:
Relationship to Patient	Alternate #:

PAST MEDICAL HISTORY FORM

Patient Name_____ Date:_____

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐
JOINT CONDITION	**YES**	**NO**
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
BLOOD PRESURE	**YES**	**NO**
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐
HEART DISEASE	**YES**	**NO**
Pace Maker	☐	☐
Heart Attack	☐	☐
Myocardial Infarction	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eye Sight	☐	☐
Fainting	☐	☐
Atherosclerotic Disease	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐
Other:		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
☐ None	☐ Sitting	☐ Low	☐ Smoking Packs/day____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol Drinks a wk____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda Cups a wk____
☐ 5+ x Week	☐ Heavy Labor		

What types of exercise do you perform? _____

What things cause stress in your life?_____

Are you taking any seizure medication? ☐YES ☐NO If yes, list them:_____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy in therapy? ☐YES ☐NO If yes List name(s):_____

List all medications you are currently taking:_____

List all surgeries in the past (including dates):_____

Are you pregnant? ☐YES ☐NO If yes, how far along?_____

Have you had any injuries related to work or any auto accidents? ☐YES ☐NO If yes list body part & date:

_____

Have you had Physical Therapy or Massage Therapy before ☐YES ☐NO If yes, where? _____

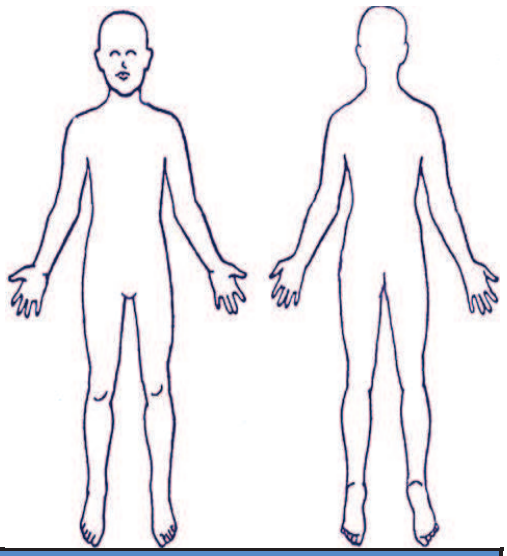
_____ _____

Signature of Patient, Parent, Guardian, Personal Representative **Date**

PAIN AND SYMPTOM STATUS REPORT

Name:_____ Date_____

Using the symbols below, please draw at the location the type
Of pain you are experiencing.



Ache	**Burning**	**Numbness**
MMM	-- -- --	O O O O
M	-- --	O O O

Pins and Needles	**Stabbing**	**Other**
/^/^/^/^	/////	**x x x x**
/^/^/	////	**x x x**

CHIEF COMPLAINT AND VISUAL ANALOG SCALE

My Chief Complaint is:_____

Date First Symptom of your problem occurred on_____

2nd Complaint_____

3rd Complaint_____

Please Circle on the scale below to indicate your <u>CURRENT</u> level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **HIGHEST LEVEL OF PAIN**

Please Circle on the scale below to indicate your <u>AVERAGE</u> level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **HIGHEST LEVEL OF PAIN**

Please Circle on the scale below to indicate your <u>WORST</u> level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **HIGHEST LEVEL OF PAIN**

Additional comments_____
_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for NY Physical Therapy & Wellness, LLC to furnish medical care and treatment necessary and proper in diagnosing or treating his/her physical condition.

_____ _____

Signature of Patient/Guardian **Date**

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third party payers to NY Physical Therapy & Wellness. A photocopy of this assignment is information necessary including Medical records, to secure payment.

_____ _____

Signature of patient/Guardian **Date**

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize NY Physical Therapy & Wellness, LLC to obtain any and all medical records concerning my care from any physician, hospital or health care professional that has provided medical care to me in the past.

I also authorize NY Physical Therapy & Wellness, LLC practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at anytime.

_____ _____

Signature of Patient/Guardian **Date**

ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at anytime.

I understand that I have the right to request that the Practice restrict its uses and disclosures of my health information for treatment, payment or health care operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.

I do not request any restrictions on the Practice's uses and disclosures of my health information for treatment, payment or health care operations. _____**(Initial)**

By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance of this consent.

_____ _____

Signature of Patient/Guardian **Date**

[ ] Patient chose not to sign acknowledgement