212-73 26th Ave
Bayside, NY 11360
www.theptdoctor.com
Tel: 718.747.2019 Fax: 718.767.6944

PATIENT NAME: (Full LEGAL NAME or as on your INSURANCE CARD)

____ ______________________________
First Last Middle Initial **Date of Birth** (MM/DD/YYYY)

____
Address: Street Apt. # City State Zip Code

Phone: (_____) _______-_________ (_____) _______-_________ (_____) _______-__________
Home Mobile Work

Emergency Contact: ________________________ ______________________ (_____) _______-__________
Name Relationship Phone

Email Address for Free Bi-weekly Newsletter:____

How would you like to receive appointment reminders? (Please check **one**)
_____ Call me at home (default) ______Call my mobile ______Text my mobile ______Email me

REFERRAL:

Please let us know who referred you so that we may thank them: ______________________________________

PAYMENT AUTHORIZATION/CERTIFICATION OF INFORMATION: (PLEASE READ AND INITIAL):

____
Initials

Assignment of Insurance Benefits
I authorize the payment of my insurance benefits to be made directly to The Physical Therapy Doctor, P.C. for all services rendered. If I receive a check directly from my insurance company in error, I will promptly deliver it to The Physical Therapy Doctor, P.C.

____
Initials

Guarantee of Payment
I understand that all payments designated as "patient's responsibility" such as co-insurances, co-payments, and deductibles are due and payable at the time of service upon check-in or statement receipt. I understand that **insurance verification and pre-authorization are not a guarantee of coverage**. I guarantee that I will pay the amount deemed "my responsibility" by my insurer and/or any **unpaid claims** by the statement due date.

____
Initials

Certification of Information
I CERTIFY THAT THE INFORMATION I HAVE PROVIDED THE PHYSICAL THERAPY DOCTOR, P.C. FOR PAYMENT INCLUDING, BUT NOT LIMITED TO, RELATED ACCIDENTS, INJURIES, ILLNESSES OR OTHER INSURERS IS ACCURATE AND TRUTHFUL.

____
Initials

Cancellation/No-Show Policy
I understand that The Physical Therapy Doctor, P.C. requires **24 HOURS NOTICE** prior to my scheduled appointment time in the event of a cancellation. I acknowledge and agree to pay the **$25 FEE FOR NO-SHOWS or LATE CANCELLATIONS** upon sign-in at my next visit. In the event that I do not have any future appointments, I agree to pay any and all fees incurred upon receipt of a statement from The Physical Therapy Doctor, P.C.

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Initials

For Medicare Patients only
I certify that the information given by me in applying for payments under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration, Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign benefits payable for physical therapy services to The Physical Therapy Doctor, P.C.

NOTICE OF PRIVACY PRACTICES:

____
Initials

I hereby acknowledge that I have received and reviewed The Physical Therapy Doctor, P.C.'s Notice of Privacy Practices. Should I have any questions regarding said notice, I understand that I can contact the practice at (718) 747-2019.

Patient or Guardian Signature ______________________________

THE PHYSICAL THERAPY DOCTOR Name: ________________________ Date of Birth: ________________________

PAIN

PLEASE CIRCLE ALL THAT APPLY

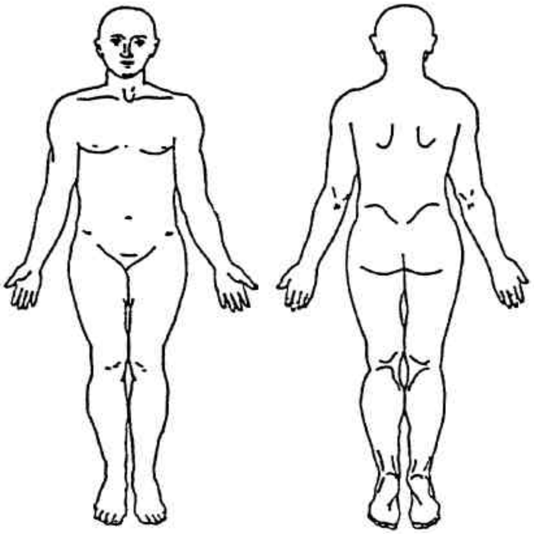
1. **Please rate your pain level on a scale of 0 to 10 (0 being no pain and 10 being the worst pain)**

At Your Worst:	0 1 2 3 4 5 6 7 8 9 10
Currently:	0 1 2 3 4 5 6 7 8 9 10
At Your Best:	0 1 2 3 4 5 6 7 8 9 10

2. **Date your PAIN BEGAN or RECENTLY BECAME WORSE**: ________________________

3. **BODY PART INVOLVED:** ________________________

PLEASE MARK BELOW WHERE YOUR PAIN IS LOCATED:



PHYSICAL THERAPISTS USE ONLY

4. **What type of pain is it?**

   Burning Dull & Achy Sharp Throbbing Shooting Numbness/Tingling

5. **How often do you experience your pain?** Constantly or Intermittently

6. **When is your pain at its worst?** Morning Afternoon Night

7. **With which of the following do you experience pain?**

   Sitting Standing Walking Lying down Only when I move All of the above

EXERCISE

8. **Do you exercise?** YES NO

9. **If YES, What type of exercise?** ________________________ **How often?** ____________

BMI

10. **Your estimated weight is:** __________

11. **Your estimated height is:** __________

GOALS

12. **What activities do you have difficulty doing? (Please be specific)** ________________________

Patient or Guardian Signature ________________________

Name: ________________________________ Date of Birth: ___________________________

TO BE COMPLETED BY BALANCE PATIENTS ONLY
PLEASE DISREGARD THIS PAGE IF IT DOES NOT APPLY TO YOU.

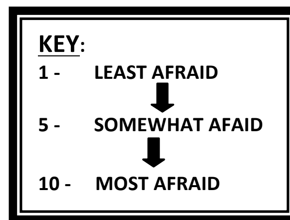
FALLS

13. Have you fallen over the past year? YES NO

14. If yes, how many times? ________________________

15. Did you sustain an injury? ________________________

FALLS EFFICACY SCALE



16. On a scale from 1 to 10, rate your FEAR OF FALLING while doing the following activities:

Activity	Score
A. Taking a bath or shower	
B. Reaching into cabinets or closets	
C. Walking around the house	
D. Preparing meals not requiring carrying heavy or hot objects	
E. Getting in and out of bed	
F. Answering the door or telephone	
G. Getting in and out of a chair	
H. Getting dressed and undressed	
I. Personal grooming (i.e. wash your face)	
J. Getting on and off the toilet	
TOTAL SCORE	

A total score of greater than 70 indicates that the person has a fear of falling.

Source: Tinetti, M., Richman, D., Powell, L. (1990). Falls Efficacy as a Measure of Fear of Falling. Journal of Gerontology. 45;239

Patient or Guardian Signature ______________________________

THE PHYSICAL THERAPY DOCTOR

SURGERIES

17. Please list ALL surgeries:

Surgery____**Year**________________________

Surgery____**Year**________________________

Surgery____**Year**________________________

Surgery____**Year**________________________

MEDICAL TREATMENTS/THERAPIES

18. Please circle any of the following treatments you have received:

Chiropractic Physical Therapy Occupational Therapy Speech Therapy Acupuncture

Massage Therapy Cortisone Injections Epidural Injections

If yes, about how many visits? ______________

FOR MEDICARE PATIENTS ONLY

Have you had any Home Care services? YES ________ NO ________

Do you have a Home Care Discharge letter? YES ________ NO ________

MEDICATIONS

19. Please list all prescription and over-the-counter medications you are currently taking (or provide a separate list):

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

CONSENT TO TREATMENT

I, the undersigned, do hereby agree and give consent for The Physical Therapy Doctor, P.C. to furnish medical care and treatment.

Signature of Patient or Legal Guardian: _________________________________**Date:** ________________

Patient or Guardian Signature ______________________________

THE PHYSICAL THERAPY DOCTOR

MEDICAL HISTORY

Please check if you have any history of the following conditions:

- Alcoholism
- Allergies
- Anemia
- Anxiety
- Arthritis
- Asthma
- Attention Deficit Hyperactivity disorder
- Balance Problems
- Blood Clot
- Bowel/Bladder Issues (Incontinence)
- Brain Injury
- Cancer - Type?__________________
- Candida (Yeast Allergy)
- Carbon Monoxide Poisoning
- Celiac Disease
- Chest Pains
- Chronic Fatigue Syndrome
- Concussion
- Depression
- Diabetes
- Diarrhea
- Difficulty Speaking
- Disc Problems
- Dizziness or History of Fainting
- Eating Disorder
- Empty Nest Syndrome
- Epilepsy
- Excessive Fatigue
- Falls
- Fever
- Fibromyalgia
- Headaches (Tension or Migraine)
- Heart Attack/Disease
- Heart Palpitations
- Hemorrhoids
- High Blood Pressure
- High Cholesterol
- Hypoglycemia
- Infectious Disease
- Incontinence
- Insomnia
- Intrusive Thoughts
- Irritable Bowel Syndrome
- Kidney Problems
- Low blood pressure
- Liver/Gallbladder Problems
- Lyme Disease
- Mental Illness/Disease
- Metal Implants
- Miscarriage
- Motor Vehicle Accident(s)
- Multiple Chemical Sensitivity
- Nausea/Vomiting
- Night Sweats
- Numbness
- Open Wounds
- Osteoarthritis
- Osteoporosis
- Pacemaker/Defibrillator
- Phobias
- Pins & Needles
- PTSD
- Radiation Treatments
- Reflux
- Rheumatoid Arthritis
- Ringing in Ears
- Seizures
- Shortness of Breath/Difficulty Breathing
- Skin Rashes
- Sleep Apnea
- Sleep Disturbances
- Stomach or Intestinal Issues
- Stroke
- Stuttering
- Substance Abuse
- Sweaty Hands/Feet
- Thyroid Dysfunction
- Ulcer
- Vision Problems

PLEASE LIST ANY OTHER PAST MEDICAL HISTORY NOT LISTED ABOVE:

____

____

Patient or Guardian Signature ______________________________