Chittenango Physical Therapy

Name:_____ Date of Birth:_____/_____/_____

SS Number:_____

Address:_____

City State Zip

Primary Phone Number:_____Secondary Phone Number:_____

E-Mail Address:_____

Appointment Reminders:

☐ Yes, please **call** my phone the day before to remind me Phone:_____

☐ Yes, please send me a **text** message the day before to remind me Phone:_____

Emergency Contact:_____ Contact Phone Number:_____

Referring Doctor:_____

Primary Insurance:_____Secondary Insurance:_____

(Please present your insurance card(s) to the receptionist - Thank you!)

Where did you hear about Chittenango Physical Therapy?

Family/Friend Print Ad Doctor Website Online Search Insurance Radio Other:_____

Designated Individuals Authorization (Optional)

List anyone you would like Chittenango Physical Therapy to be able to correspond with about your care.
(Example: Family Members, Parents, Siblings, Spouse, Lawyer, Caregiver etc.)

I hereby authorize one or all of the designated parties below to request and receive any of my protected health information regarding treatment, payment or administrative operations. I understand that the identity of these designated parties will be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____

Patient Signature

_____

Date

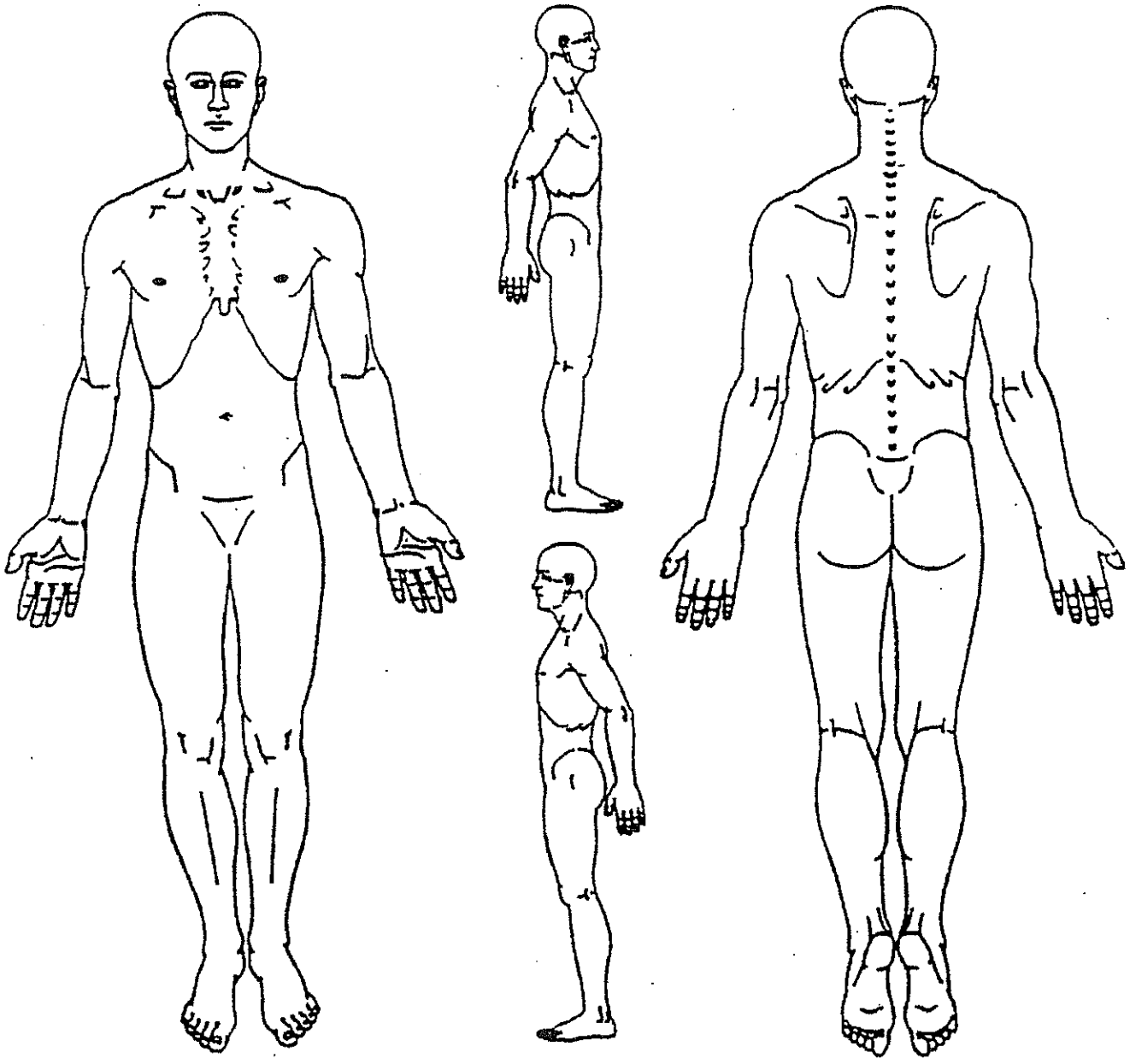
Name:_____ Date:_____

On the diagram below, please indicate where you are experiencing pain right now.
Please circle the area and use the following letters to show what type of pain it is:

(A=Ache, B=Burning, N=Numbness, P=Pins and needles, S=Stabbing, O=other)

Please rate your pain from 0 = None to 10= Worst:

Least:_____ Worst:_____ Average Daily:_____



Name:_____ Date:_____ Next Doctor's Visit:_____

Briefly describe your current injury/symptoms:_____

_____

Date of onset and cause of injury/symptoms:_____

_____

Overall your symptoms have been... (circle one) (Improving) (Worsening) (Staying the same)

Have you recently experienced any numbness/ tingling/ Altered sensation anywhere in your body? **YES / NO**

If YES, Where? :_____

What makes your symptoms worse?_____

What makes your symptoms better?_____

Have you experienced these symptoms before? **YES or NO** If YES, When?_____

What treatments, if any, have you received in the past for your current injury?_____

List any brace/assistive device you currently use:_____Average hours of sleep per night:_____

Circle any of the following which you have had recently: X-Ray MRI CT scan Bone Scan DXA Scan Ultrasound

List any medications that you are currently taking **(Including dosage) (or provide the front office with a list of medications to photocopy)**

_____

_____

Are you currently working; what is your occupation?_____

Briefly describe your occupation demands:_____

Circle any of the medical conditions that apply to you:

Alzheimer's	**Dizziness/ Double vision**	**Metal Implants**	**Pinched Nerve**
Anemia	**GI Disorder**	**Multiple Sclerosis**	**Pregnancy**
Anxiety Disorder	**Headaches**	**Nerve Disorder**	**Psychological Disorder**
Back Disorder	**Heart Problems**	**Neuropathy**	**Rheumatoid Arthritis**
Cancer	**High Cholesterol**	**Osteoarthritis**	**Sciatica**
Circulatory Problems	**High Blood Pressure**	**Osteoporosis**	**Skin Disease**
COPD/Respiratory	**Incontinence**	**Pacemaker**	**Stroke**
Depression	**Kidney Problems**	**Parkinson's Disease**	**Tuberculosis**
Diabetes	**Liver Problems**	**Pelvic Pain**	**Ulcer**

Other Medical Conditions:_____

List of major surgeries and dates:_____

Approximate amount of time you can tolerate: Sitting_____ Standing_____ Walking_____

Currently I am experiencing (circle all that apply):

Fever/Chills/Sweats	**Shortness of Breath**	**Weight Loss/ Gain**	**Changes in Appetite**
Nausea/Vomiting	**Difficulty Swallowing**	**Increased Pain at Night**	**Changes in Bowel/ Bladder Func.**

☐ Poor Balance (Falls)? If YES:. How many falls have you had in the last year?_____

During the past month, have you often been bothered by feeling down, depressed or hopeless? **YES or NO**

During the past month, have you often been bothered by little interest in pleasure in doing things? **YES or NO**

Do you participate in any form of exercise on a regular basis? **YES or NO**

If YES... What kind?_____

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

Your protected health information will be used by Chittenango Physical Therapy or disclosed to others only for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Prior to signing this form, you may review the full Notification of Privacy PRactices for a more detailed description of how your protected health information may be used or disclosed.

I have been notified of the Privacy Practices for Chittenango Physical Therapy.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

Signature of Patient Representative:_____
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient