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

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

Medical History- Do you have any of these conditions? (Males)

NEUROLOGICAL
- ☐ Stroke
- ☐ Tia (Mini strokes)
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Dementia
- ☐ Seizures
- ☐ Peripheral neuropathy
- ☐ Pudendal neuralgia

MENTAL HEALTH
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Anxiety disorder
- ☐ PTSD
- ☐ Insomnia
- ☐ OCD
- ☐ Abuse/Trauma

VISION AND HEARING
- ☐ Hard of hearing

DERMATOLOGICAL
- ☐ Psoriasis
- ☐ Eczema

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart disease
- ☐ Congestive heart failure
- ☐ Angina
- ☐ Heart attack
- ☐ Cardiac/defibrillator
- ☐ Vascular disease

HEMATOLOGICAL/IMMUNE
- ☐ Anemia
- ☐ Sickle cell
- ☐ Vitamin deficiency
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Auto-immune

CANCER
- ☐ Type:_____
- ☐ Treatment:_____

RESPIRATORY
- ☐ COPD/emphysema
- ☐ Bronchitis
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Seasonal allergies

ENDOCRINE
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

DIGESTIVE
- ☐ Acid reflux/GERD
- ☐ Diverticulosis
- ☐ Constipation
- ☐ Chronic diarrhea
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease
- ☐ Celiac disease
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Hemorrhoids
- ☐ colostomy/Ileostomy

UROLOGICAL
- ☐ Overactive bladder
- ☐ Urinary incontinence
- ☐ Interstitial cystitis
- ☐ Bladder pain syndrome
- ☐ Bladder infections (UTI'S)
- ☐ Kidney disease
- ☐ Stones

MUSCULOSKELETAL
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Tailbone/pelvis trauma
  - ☐ Trauma from recent or past fall
  - ☐ Trauma from vehicle accident
- ☐ Diastasis Recti
- ☐ Sciatica
- ☐ Stenosis
- ☐ Scoliosis
- ☐ Herniated disc
- ☐ Degenerative discs
- ☐ Fracture:_____
- ☐ Sprain:_____
- ☐ Low back pain
- ☐ Hip pain

MALE=PROSTATE
- ☐ Enlarged Prostate
- ☐ Prostate infections
- ☐ Chronic Prostatitis
- ☐ Prostate Pain
- ☐ Achieving erection
- ☐ Maintaining erection
- ☐ Difficulty with ejaculation
- ☐ erectile/ejaculation pain
- ☐ infertility

Please list any medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any of these symptoms? (Male & Female)

GENERAL BODY SYMPTOMS
- ☐ Fever, chills, night sweats
- ☐ Weight changes
- ☐ Unexplained pain
- ☐ Excessively chronically tired
- ☐ Dizziness, fainting
- ☐ Trouble sleeping

SKIN, HAIR, AND NAILS
- ☐ Dry Skin, Itching, rash
- ☐ Irregularly shaped moles
- ☐ Unexpected bruising
- ☐ Unexpected hair loss
- ☐ Changes in nail appearance

NERVES AND MEMORY
- ☐ Headaches
- ☐ Tingling, numbness
- ☐ Forgetfulness, confusion
- ☐ Trouble concentrating

MOOD AND FEELINGS
- ☐ Anxiousness, nervousness
- ☐ Sadness, hopelessness
- ☐ Lost of interests/purpose
- ☐ Wanting to die

EYES AND VISION
- ☐ Drooping eyelids

EARS, NOSE, MOUTH, AND THROAT
- ☐ Swollen glands
- ☐ Dry mouth

HEART AND VESSELS
- ☐ Chest pain
- ☐ Racing heart
- ☐ Dizziness upon standing
- ☐ Swelling in feet or hands

LUNGS AND BREATHING
- ☐ Chest Pain
- ☐ Shortness of breath
- ☐ Frequent coughing/sneezing
- ☐ Bloody Phlegm

STOMACH AND DIGESTION
- ☐ Indigestion/heartburn
- ☐ Nausea, vomiting
- ☐ Change in appetite
- ☐ Stomach Pain, Cramping
- ☐ Bloating

BOWELS AND DEFECATION
- ☐ Constipated
- ☐ Diarrhea
- ☐ Fecal Leakage
- ☐ Incomplete emptying of bowels
- ☐ Feeling of rectal obstruction
- ☐ Changes in stool color/formation
- ☐ Effortful bowel movements
- ☐ Painful bowel movements
- ☐ Rectal or tailbone pain

BLADDER AND URINATION
- ☐ Urine leakage
- ☐ Strong, sudden urges to void
- ☐ Bladder or urethral pain
- ☐ Pressure, burning sensations
- ☐ Frequent toilet visits
- ☐ Incomplete bladder emptying
- ☐ Urine stream changes
- ☐ Weak urine stream

GENITALS
- ☐ Pain, itching or burning
- ☐ Redness or white patches
- ☐ Feeling of warmth
- ☐ Feeling of coldness
- ☐ Lumps or wounds
- ☐ Change in libido/sexual respose
- ☐ Genital pain with sitting
- ☐ Pain during or after sex

FEMALE REPRODUCTIVE
- ☐ Vaginal dryness
- ☐ Clitoris or vaginal pain
- ☐ Pelvic pressure or pain
- ☐ Falling out feeling
- ☐ Vaginal bulge
- ☐ Difficult pregnancy or labor

MALE REPRODUCTIVE
- ☐ Erectile issues
- ☐ Tip or shaft or penis pain
- ☐ Scrotal or testicle pain
- ☐ Perineal pain
- ☐ Prostate pain

SPEECH AND SWALLOWING
- ☐ Voice or speech changes
- ☐ Word finding difficulties

MUSCLE AND BONES
- ☐ Diffuse muscle aches
- ☐ Muscle tightness
- ☐ Muscle spasm
- ☐ Tremors
- ☐ Shaking
- ☐ Lake of coordination
- ☐ arm/leg weakness
- ☐ Hand or finger weakness
- ☐ Poor posture
- ☐ Joint stiffness
- ☐ Joint swelling

STABILITY AND BALANCE
- ☐ Falls-current or history of
- ☐ Near falls
- ☐ Fear of falling
- ☐ Stumbling legs give away
- ☐ Unsteadiness
- ☐ Tripping over feet/toes

DIFFICULTY WITH:
- ☐ Using toilet
- ☐ Sitting
- ☐ Getting out of bed
- ☐ Standing up
- ☐ Walking
- ☐ Using stairs
- ☐ Running or jumping
- ☐ Exercising for health
- ☐ Taking care of a loved one
- ☐ Work/school performance
- ☐ Driving a vehicle

Are you currently exercising?

If so, what type:_____

How often:_____

Where are you exercising?

_____

Intensity:
- ☐ High
- ☐ Medium
- ☐ Low

Height:_____ Weight:_____

Other Symptoms:

_____

_____

_____