Chittenango Physical Therapy

Name:______________________________________ Date of Birth:_______/______/_______

SS Number:________________________________

Address:____

City State Zip

Primary Phone Number:________________Secondary Phone Number:___________________

E-Mail Address:____________________________________

Appointment Reminders: (Circle one) Please **CALL** or **TEXT** my phone the day before to remind me

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:_____________________________

Cancelation/No Show Policy: By signing this form you agree to a 24 hour notice prior to your appointment for any appointment cancellations. Any cancellations with <24 hour notice or a no show will result in a $20 fee charged to your account. In the event of an emergency or bad weather the $20 cancellation fee will be waived. (Effective 4/1/24) If you cancel or no show 3 or more visits then you will be put “on call”. Meaning you will have to call us the day of to see if we have any openings.

____

Patient Signature

____

Date

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

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:____________