Saratoga Physical Therapy Associates
Patient Information Form

Name: _____
Address: _____ Phone: _____
City: _____ Zip Code _____
Date of Birth: _____ Age: _____ Occupation _____

Referring Doctor _____ Phone _____

PRIMARY INSURANCE

Insurance Company Name _____
Subscriber (Policy Holder) _____
I.D. Number _____ Group _____
Subscriber Name _____ DOB _____
Subscriber Address (if different than patient) _____
For patients under 18: _____
Guardian Name _____ DOB _____
Guardian Address (if different than patient) _____

SECONDARY INSURANCE (IF ANY)

Insurance Company Name _____
Address _____
I.D. Number _____ Group _____
Subscriber (Policy Holder) _____
Policy Holder DOB _____

IF INJURY WAS WORK RELATED, FILL OUT THIS SECTION

Name of Employer _____ Phone _____
Address of Employer _____
Worker's Compensation Insurance Name _____
Address of Insurance _____
Adjustor Name _____ Phone _____
City Injury Occurred _____ Injury Date _____
Claim# _____ WCB# _____ Social Security# _____

IF INJURY WAS FROM MOTOR VEHICLE ACCIDENT, FILL OUT THIS SECTION

Name Of **YOUR** Auto Insurance Carrier _____
Address _____
Accident Date _____ Policy # _____
Claim # _____ Name of Insured _____
Adjustor _____ Adjustor Phone _____

I authorize Saratoga Physical Therapy Associates to release information necessary to bill on my behalf for the above-named patient or myself. I further understand that I will be responsible for any portion of the bill including deductible, and any coinsurance amount not covered by my insurance plant.

Signature _____ **Date** _____

If patient is a minor, I authorize Saratoga Physical Therapy Associates to treat my child.

Signature _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
SARATOGA PHYSICAL THERAPY ASSOCIATES

I, _____, understand that as part of my health care, Saratoga Physical Therapy Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that information serves as:

A basis for planning my care and treatment;
A means to facilitate communication among the many healthcare professionals who contribute to my care;
A source of information for applying my diagnosis and surgical information to my bill;
A means by which a third-party payer can verify the services billed were actually provided; and
A tool for healthcare operations at Saratoga Physical Therapy Associates such as assessing quality of care and reviewing the competence of healthcare professions

I understand that as part of Saratoga Physical Therapy Associates treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of how Saratoga Physical Therapy Associates may use and disclosure my protected healthcare information. I further understand that Saratoga Physical Therapy Associates reserves the right to change its **Notice of Privacy Practices**. Should Saratoga Physical Therapy Associates change its **Notice of Privacy Practices**, an amended copy will be posted in a prominent location in the practice site, or, upon my request, an amended copy will be sent to the address I have provided.

I agree that Saratoga Physical Therapy Associates may do the following:

PLEASE INDICATE WITH AN "X"

Leave an appointment message on:		Leave other medical info on:	
Answering machine?	____	Answering machine?	____
Office voice mail?	____	Office voice mail?	____
W/ another person?	____	W/ another person?	____
Send through mail?	____	Send through mail?	____
Cell phone?	____	Cell phone?	____

Person (s) Authorized To Communicate With

_____

_____

_____

Patient's Signature or Signature of Personal Representative

_____

Date

Patient History Questionnaire - PHQ

Saratoga Physical Therapy Associates

Patient Name: _____ **Date:** _____

Occupation: _____ **Are you:** ***on restrictions / out of work*** **(circle if appropriate)**

Height: _____ **Weight:** _____

1. Injury Date: _____ **Surgery Date:** _____

2. Please provide a brief description of your symptoms:

_____

_____

_____

3. How often do you experience your symptoms?

1. Constantly (76-100% of the day)
2. Frequently (51-75% of the day)
3. Occasionally (26-50% of the day)
4. Intermittently (0-25% of the day)

4. How are your symptoms changing?

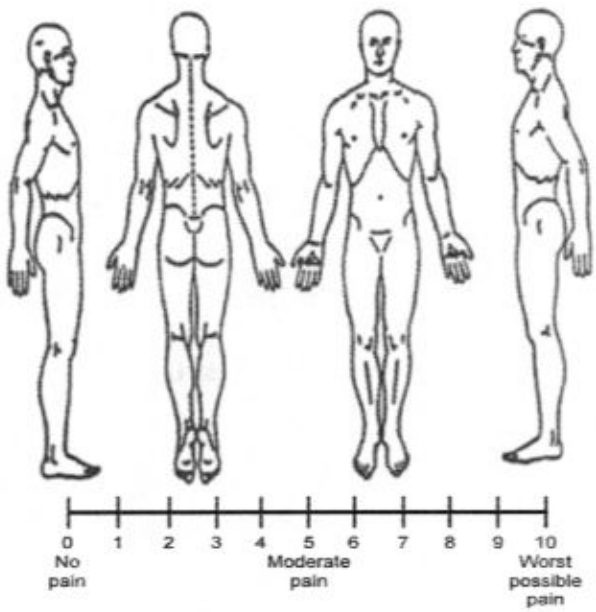
1. Getting Better
2. Not Changing
3. Getting Worse

5. *Pain Description*: Please describe the quality of your pain. Circle all that apply:

Dull Ache	Shooting
Sharp	Burning
Numbness	Tingling

Other: _____

Please mark on the diagrams the location and intensity of your pain...



6. Have you had a previous history of these symptoms?

1. Yes 2. No

7. *Aggravating Factors*: Circle all activities that make your condition worse...

Sitting	Standing	Walking
Stairs- Up	Stairs- Down	Bending
Sneezing/Coughing	Lying Down	_____
_____	_____	_____

8. In general, would you say your overall health is...

1. Good 2. Fair 3. Poor

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Saratoga Physical Therapy Associates

9. Medical History (self) :

- ○ No Known Significant PMH to Affect Treatment
- ○ Alzheimer's
- ○ Cardiovascular Disease
- ○ Cauda Equina Syndrome
- ○ Cerebral Vascular Accident
- ○ Current Infection
- ○ Diabetes Mellitus Type 1
- ○ Diabetes Mellitus Type 2
- ○ Fibromyalgia
- ○ Fracture or Suspected Fracture
- ○ High Blood Pressure
- ○ _____
- ○ History of Cancer
- ○ Huntington's
- ○ Immunosuppression
- ○ Lupus
- ○ Muscular Dystrophy
- ○ Obesity
- ○ Osteoarthritis
- ○ Parkinson's
- ○ Rheumatoid Arthritis
- ○ Traumatic Brain Injury
- ○ _____
- ○ _____

10. *Diagnostic Imaging*: (x) appropriate and note which facility image was taken

X-Ray: ( ) _____ (Facility Name) MRI: ( ) _____ (Facility Name)

CT Scan: ( ) _____ (Facility Name) Other: ( ) _____ (Facility Name)

11. Please list your current medications:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

12. What are your goals for therapy?

_____
_____
_____

Patient Signature: _____ **Date:** _____