Saratoga Physical Therapy Associates
Patient Information Form

Name:_____MALE_____FEMALE_____
Address_____Home Phone _____
City_____State_____Zip Code_____
Date of Birth_____Age_____Cell Phone_____
Occupation_____Work Phone_____
Spouse's Name_____Spouse"s Date of Birth_____

Referring Doctor_____ Phone_____

PRIMARY INSURANCE

Ins Company Name_____
I.D.Number_____Group_____
SubscriberName(POLICY HOLDER)_____DOB_____
Subscriber Address(if different than patient)_____
Subscriber's Relationship_____ Phone_____

For patients under 18:
Guardian Name_____DOB_____Relationship_____
Guardian Address(if different then patient)_____
Guardian Phone(if different then patient)_____

SECONDARY INSURANCE (IF ANY)

Ins Company Name_____
Address_____
I.D.Number_____Group_____
Subscriber (Policy Holder)_____
Policy Holder DOB_____ Relationship_____

THIRD INSURANCE (IF ANY)

Ins Company Name_____
Address_____
I.D.Number_____Group_____
Subscriber (Policy Holder)_____
Policy Holder DOB_____ Relationship_____

IF INJURY WAS WORK RELATED, FILL OUT THIS SECTION

Name of Employer_____Phone_____
Address of Employer_____
Worker's Compensation Insurance Name_____Phone_____
Address of Insurance_____
Adjuster Name_____Adjuster Phone_____
City Injury Occurred_____ Injury Date_____
Claim #_____WCB #_____Social Security #_____

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IF INJURY WAS FROM MOTOR VEHICLE ACCIDENT, FILL OUT SECTION

Name of **YOUR** Auto Insurance Carrier_____
Address_____
Accident Date_____Policy #_____
Claim #_____Name of Insured_____
Insured' s Date of Birth_____
Adjustor_____ Adjustor Phone_____

****PLEASE SIGN FOR ALL INSURANCE PURPOSES****

I authorize Saratoga Physical Therapy Associates to release information necessary to bill on my behalf for myself or the above-named patient. 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**_____

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?

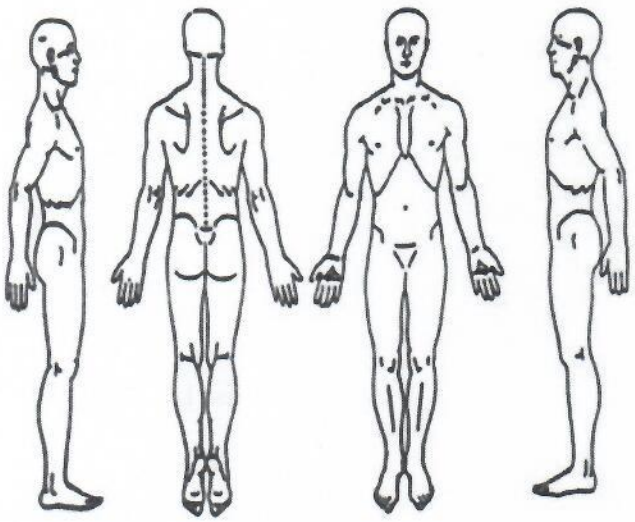
1. Getting Better
2. Not Changing
3. Getting Worse

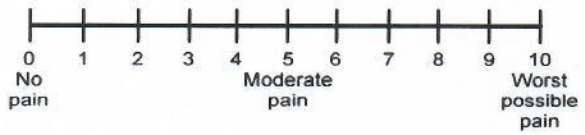
5. *Pain Description*: Please describe the quality of your pain. Circle all that apply:

Dull Ache	Shooting
Sharp	Burning
Numbness	Tingling

Other: _____

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





Patient History Questionnaire – Page 2

Saratoga Physical Therapy Associates

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

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

1. Good 2. Fair 3. Poor

9. Medical History:

- ○ 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: ( ) _____ MRI: ( ) _____

Facility Name Facility Name

CT Scan: ( ) _____ Other: ( ) _____

Facility Name Facility Name

Patient History Questionnaire - PHQ

11. Please list your current medications:

_____	_____	_____
_____	_____	_____
_____	_____	_____

12. What are your goals for therapy?

_____

_____

_____

Patient 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 this
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 that services billed were actually provided; and
A tool for healthcare operations of Saratoga Physical Therapy Associates such as assessing quality of care and reviewing the competence of healthcare professionals

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 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 _____