Saratoga Physical Therapy Associates

5 Care Lane Saratoga Springs, NY 12866 - 2388 Rte 9, Ste 102 Malta, NY 12020

Name_____**Male**_____**Female**_____
Address_____**City**_____
State_____**Zip Code**_____ **Date of Birth (DOB)** _____**Age** _____
Home Phone _____**Cell** _____ **Work** _____
Spouse's Name_____**Spouse's DOB**_____

Referring Doctor_____ **Phone**_____

For patients under 18

Guardian Name_____**DOB**_____**Relationship**_____
Guardian Address (if different from patient)_____
Guardian Phone (if different from patient)_____

PRIMARY INSURANCE

Insurance Company Name_____
ID Number _____**Group**_____
Subscriber Name (Policyholder) _____**DOB**_____
Subscriber Address (if different than patient) _____
Subscriber's Relationship_____ **Phone**_____

SECONDARY INSURANCE (IF ANY)

Insurance Company Name_____
ID Number _____**Group**_____
Subscriber Name (Policyholder) _____**DOB**_____
Subscriber Address (if different than patient) _____
Subscriber's Relationship_____ **Phone**_____

THIRD INSURANCE (IF ANY)

Insurance Company Name_____
ID Number _____**Group**_____
Subscriber Name (Policyholder) _____**DOB**_____
Subscriber Address (if different than patient) _____
Subscriber's Relationship_____ **Phone**_____

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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**_____
Insured's Date of Birth_____
Adjustor_____ **Adjustor Phone**_____

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 #**_____

****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 plan.

Signature_____ **Date**_____

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

Signature_____ **Date**_____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

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
- 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:

_____Answering machine
_____Office voicemail
_____With another person
_____Send through mail
_____Cell phone

Leave other medical info on:

_____Answering machine
_____Office voicemail
_____With another person
_____Send through mail
_____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: _____

Occupation: _____ **Work Status (circle):** **Full Time** **Part Time** **Out of Work**

Retired **Light Duty**

Height: _____ **Weight:** _____ **Any restrictions:** _____

Injury Date: _____ **Surgery Date:** _____

1. Describe your symptoms: _____

_____

2. How did your symptoms begin? _____

_____

3. Do you have a previous history of these symptoms? **Yes** **No**

If yes, have you received physical therapy for these symptoms? **Yes** **No**

If yes, where? _____

4. Are your symptoms:

Constant (76-100% of the day)
Frequent (51-75% of the day)
Occasional (26-50% of the day)
Intermittent (0-25% of the day)

5. Do your symptoms interfere with your usual daily activities?

Not at all Quite a bit A little bit
Extremely Moderately

6. Describe the quality of your pain.
Circle all that apply:

Dull Ache Shooting
Sharp Burning
Numbness Tingling
Other: _____

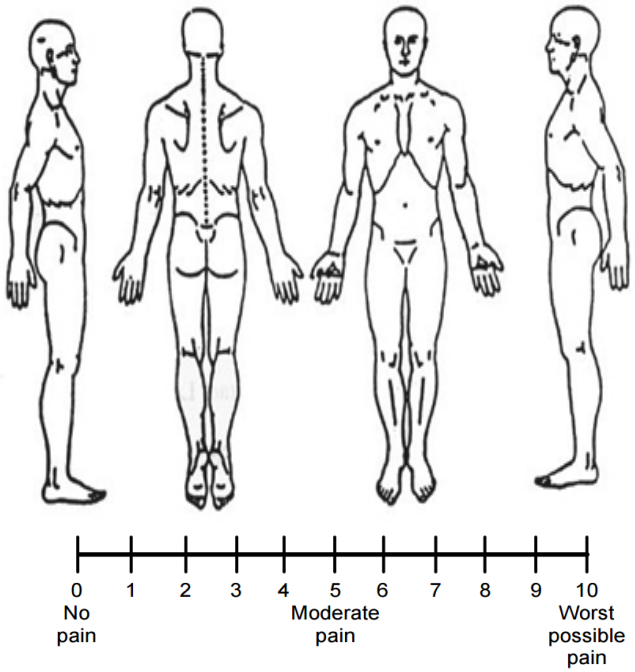
7. What makes your symptoms worse?

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

8. How are your symptoms changing?

Better No change Worse

9. On the digram below, mark the location of your injury/pain and then circle the intensity of your pain on the scale:



Patient History Questionnaire (PHQ)

Saratoga Physical Therapy Associates

10. In general, is your overall health:

Excellent Very Good Good Fair Poor

11. Medical History:

- ○ **No Known Significant PMH to Affect Treatment**
- ○ **Alzheimer disease**
- ○ **Cardiovascular disease**
- ○ **Cauda Equina Syndrome**
- ○ **Cerebral Vascular Accident**
- ○ **Current Infection**
- ○ **Diabetes Mellitus Type 1 / Type 2**
- ○ **Fibromyalgia**
- ○ **Fracture or Suspected Fracture**
- ○ **High Blood Pressure**
- ○ **History of Cancer**
- ○ **Huntington disease**
- ○ **Immunosuppression**
- ○ **Lupus**
- ○ **Muscular Dystrophy**
- ○ **Obesity**
- ○ **Osteoarthritis**
- ○ **Parkinson disease**
- ○ **Pregnancy (Due Date: _____)**
- ○ **Rheumatoid Arthritis**
- ○ **Traumatic Brain Injury**
- ○ **** Pacemaker / Defibrillator ****
- ○ _____
- ○ _____
- ○

12. Diagnostic Imaging: Have you had recent images related to these symptoms?

If yes, note the date and facility where these were taken.

X-Ray _____ **MRI** _____
Facility Name / Date **Facility Name / Date**

CT Scan _____ **Other** _____
Facility Name / Date **Facility Name / Date**

13. List your current medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____

14. What are your goals for physical therapy?

_____
_____
_____

Patient Signature: _____ **Date:** _____