PROGRESSIVE PHYSICAL THERAPY, P.C.

PATIENT INFORMATION
(CONFIDENTIAL)

(PLEASE PRINT)

CELLULAR #: _____

S.S.#: _____ HOME PHONE #: _____ BUSINESS PHONE #: _____

PATIENT: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

IF CHILD, PARENT OR GUARDIAN'S NAME AND RELATIONSHIP: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

BIRTHDATE: _____ **MARITAL STATUS:** SINGLE MARRIED WIDOWED DIVORCED
(PLEASE CIRCLE)

EMPLOYER NAME: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

REFERRING DOCTOR: _____

FAMILY DOCTOR: _____ PHONE NUMBER: _____

ADDRESS: _____
(IF NOT PROVIDED, WE ARE UNABLE TO FORWARD)

WHICH DR'S DO YOU WANT YOUR REPORT SENT TO?: _____

WERE YOU INJURED ON THE JOB? YES _____ NO _____ IF YES, DATE: _____

WAS AN AUTOMOBILE INVOLVED? YES _____ NO _____ IF YES, DATE: _____

DATE OF ONSET OF INJURY/ILLNESS: _____

WERE YOU INVOLVED IN ANY OTHER ACCIDENT? YES _____ NO _____

HAVE YOU HAD PHYSICAL THERAPY BEFORE? YES _____ NO _____ WHEN? _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____ PHONE #: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Progressive Physical Therapy, P.C., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance claim submissions. My signature below will also serve as authorization for today's and future treatment, unless I rescind such authorization in writing.

_____ _____
PATIENT SIGNATURE (If minor, parent or guardian Signature) DATE

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Progressive Physical Therapy, P.C., for any services furnished to me by the therapists. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, co-insurance, and non-covered charged services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
PATIENT SIGNATURE DATE

PROGRESSIVE PHYSICAL THERAPY, P.C.

MEDICAL HISTORY

PLEASE INDICATE EACH CONDITION THAT YOU HAVE BEEN TOLD YOU HAVE (OR HAD)

HEART DISEASE	N	Y	STROKE	N	Y	EPILEPSY/SEIZURES	N	Y
CIRCULATION PROBLEM	N	Y	OSTEOARTHRITIS	N	Y	THYROID DISORDER	N	Y
HIGH/LOW BLOOD PRESSURE	N	Y	RHEUMATOID ARTHRITIS	N	Y	OSTEOPOROSIS/OSTEOPENIA	N	Y
DIABETES	N	Y	BALANCE PROBLEMS	N	Y	ANXIETY/DEPRESSION	N	Y
ASTHMA/EMPHYSEMA	N	Y	FIBROMYALGIA	N	Y	HIGH CHOLESTEROL	N	Y
DIZZINESS/VERTIGO	N	Y	HEADACHES/MIGRAINES	N	Y	HEARING LOSS	N	Y

CANCER..... NO YES,_____

BLOOD-BORNE DISEASES ..... NO YES, _____

DO YOU HAVE ANY ALLERGIES? (including tape, latex, iodine)..... NO YES,_____

HAVE YOU BROKEN ANY BONES? ..... NO YES,_____

DO YOU TAKE ANY MEDICATIONS? Please List:..... NO YES,_____

HAVE YOU HAD SURGERY? Please List..... NO YES,_____

DO YOU HAVE ANY FOREIGN OBJECTS IN YOUR BODY (PINS, RODS, VALVES, PACEMAKER)?. ..... NO YES,_____

ANYTHING NOT LISTED ABOVE THAT YOU FEEL WE SHOULD BE AWARE OF? ..... NO YES,_____

ARE YOU PREGNANT? ..... NO YES,_____

DO YOU SMOKE? ..... NO YES

LIFESTYLE DESCRIPTION: _____

SPORTS AND ACTIVITIES: _____

WORK ACTIVITIES: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE PROGRESSIVE PHYSICAL THERAPY, P.C., TO RELEASE ANY INFORMATION TO MY PHYSICIANS, INSURANCE COMPANY OR ATTORNEY, OR THEIR REPRESENTATIVES, REGARDING MY CONDITION, INCLUDING MY HISTORY, MEDICAL CARE, PHYSICAL FINDINGS, DIAGNOSIS AND/OR PROGNOSIS.

_____ _____

PATIENT SIGNATURE DATE

(IF MINOR, PARENT OR GUARDIAN SIGNATURE)

AND/OR

I, _____, ALLOW PROGRESSIVE PHYSICAL THERAPY, P.C., TO PROVIDE ALL/ANY OF MY MEDICAL OR PERSONAL INFORMATION TO _____, MY _____.

PHOTO ID WILL BE REQUIRED. (RELATIONSHIP TO PATIENT)

_____ _____

PATIENT SIGNATURE DATE

CONSENT FOR TREATMENT

I, OR MY REPRESENTATIVE, RECOGNIZING THE NEED FOR CARE, CONSENT TO ALL SERVICES ORDERED OR DEEMED APPROPRIATE BY MY PHYSICIAN AND/OR PHYSICAL THERAPIST.

_____ _____

PATIENT SIGNATURE DATE

Patient info form 04/12

700 Broadway • Massapequa, NY 11758 • Phone: (516) 797-7003 • Fax: (516) 797-7336

FUNCTIONAL AND FALLS RISK ASSESSMENT

(REQUIRED BY MEDICARE)

OPTIMAL INSTRUMENT – BASELINE

Name: _____ Date: _____

Instructions: Please circle the level of difficulty you have for each activity today	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Balancing	1	2	3	4	5	9
2. Walking-short distance	1	2	3	4	5	9
3. Walking-long distance	1	2	3	4	5	9
4. Walking-outdoors	1	2	3	4	5	9
5. Climbing stairs	1	2	3	4	5	9
6. Jumping	1	2	3	4	5	9
7. Running	1	2	3	4	5	9
8. Lying flat	1	2	3	4	5	9
9. Rolling over	1	2	3	4	5	9
10. Moving-lying to sitting	1	2	3	4	5	9
11. Sitting	1	2	3	4	5	9
12. Standing	1	2	3	4	5	9
13. Bending/stooping	1	2	3	4	5	9
14. Squatting	1	2	3	4	5	9
15. Kneeling	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9
22. Feed/Drink	1	2	3	4	5	9
23. Dress Upper Body	1	2	3	4	5	9
24. Dress Lower Body	1	2	3	4	5	9
25. Toileting	1	2	3	4	5	9
26. Wash/Bathe	1	2	3	4	5	9

1. **From the above list, choose three (3) activities, in order of greatest importance, you would most like to be able to do without any difficulty: 1._____2._____3._____**

2. **Have you had (please check):**
   _____ 2 or more falls in the past year?
   _____ any falls with injury in the past year?

CURRENT MEDICATIONS/SUPPPLEMENTS

(REQUIRED BY MEDICARE)

Name: _____ Date: _____

Medication Name (Prescriptions and Over the counter)	**Dosage**	**How often do you take?**	**Please check if other than pill form**

Vitamins, Minerals, Herbal, Dietary Supplements	**Dosage**	**How often do you take?**	**Please check if other than pill form**

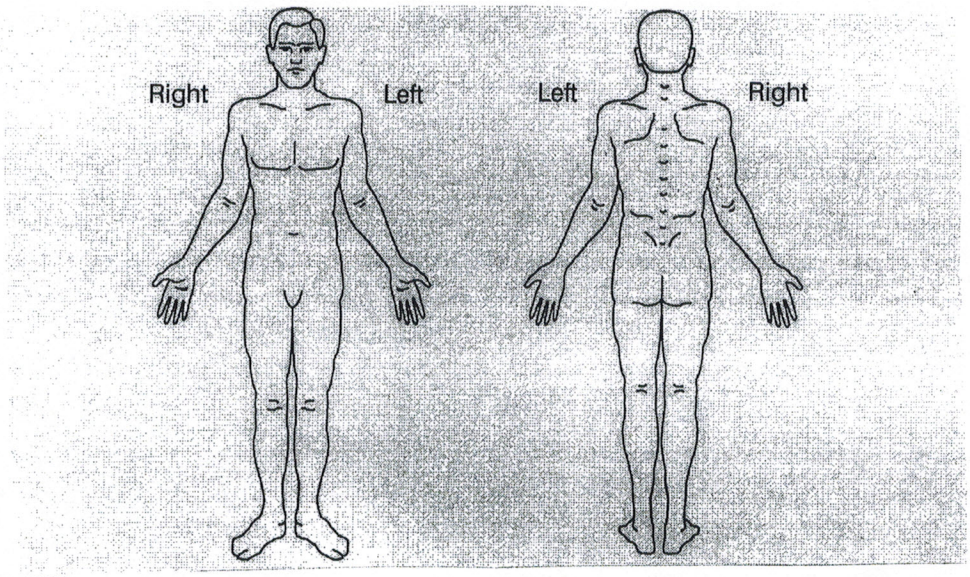
PAIN ASSESSMENT

(REQUIRED BY MEDICARE)

Name: _____ Date: _____

Weight: _____ Height: _____

1. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



2. Describe the pain: _____

_____

_____

3. Rate your pain by circling the number that best describes the WORST pain you have had in the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Pain Possible

4. Rate your pain by circling the number that best describes the LEAST pain you have had in the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Pain Possible

5. List any activities/positions that increase or decrease your pain.

Increase: _____

Decrease: _____

6. Is there anything else you would like to tell us about your pain? _____

_____

_____