SportsCare Physical & Aquatic Therapy

Medical/Physical History Form

NECK/UPPER EXTREMITIES

Patient Name:_____ **Diagnosis:** _____ **Date:** _____

Age _____ **Height:** _____**inches** **Weight:** _____**lbs.**

Name of your doctor: _____ **Type of doctor:**

Date of Injury: _____. **Date of Surgery:**_____.

History of present illness/injury/pain:_____.

Primary Concern: (***Why am I here for physical therapy):***

Check all that apply:

1. Base level of function: □ house cleaning □ laundry □ reaching □ twisting hand/arm □ grasping □ lifting
(was able to do) □ taking off/putting on shirt/bra □ pushing object □ pulling object □ turning head

2. Functional limitation(s): □ house cleaning □ laundry □ reaching □ twisting hand/arm □ grasping □ lifting
(can't do) □ taking off/putting on shirt/bra □ pushing object □ pulling object □ turning head

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Pain scale: ***(0 is best, 10 is worst)*****>>> worst:** **current:** **at best:**

Pain description: **Pain behavior in 24 hour cycle:** **Pain frequency:**

Aggravating factors:

Better with:

General Health:

Previous history of similar symptoms: **How many episodes?** **The year of 1st episode?** _____

History of falls: **how many?** None

Medical History: □ No know significant medical history

□ Heart disease	□ Stroke	□ Joint replacement	□ Strain
□ Diabetes Type I	□ High blood pressure	□ Fibromyalgia	□ Sprain
□ Diabetes Type II	□ Obesity	□ Osteoarthritis	□ Bone fracture
□ Fainting spells	□ Pacemaker	□ Rheumatoid arthritis	□ Tendonitis
□ Lupus	□ Parkinson	□ Muscular dystrophy	□ Bursitis
□ Alzheimer's/Dementia	□ Traumatic brain injury	□ Cancer	□ Spinal surgeries
□ Hepatitis	□ Seizures	□ Shortness of breath	□ Allergies: _____

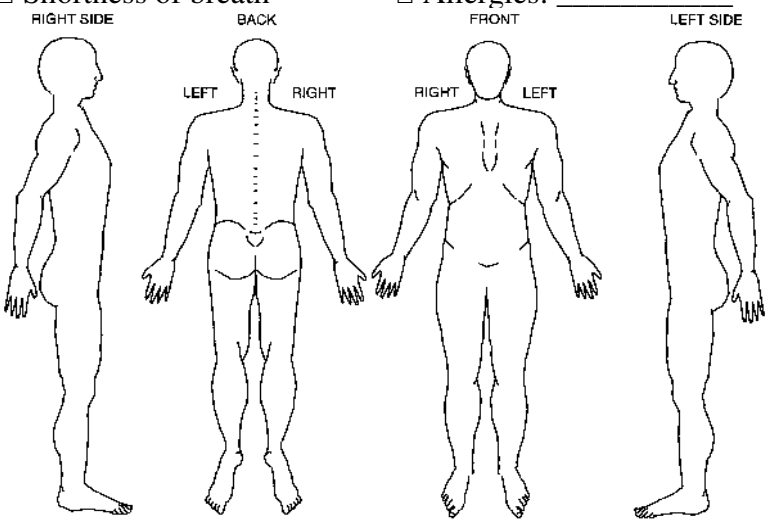
Diagnostic Testing/Imaging: □ MRI □ CT scan □ X ray Findings:

_____

What are your goals in physical therapy?

_____

Identify the area(s) of your concern by moving your cursor over the site(s) of your symptoms and checking them off (X) >>>



OFFICE USE ONLY

Total Score: ____ pts; _____ %

Total Score: ____ pts; _____ %

SportsCare Physical Therapy, PC
814 Fulton Street
Farmingdale, NY 11735

MY MEDICATION RECORD

List prescriptions, over-the-counter drugs, vitamins and herbal medicines.

Patient name: _____ Date: _____

Allergies: _____

Pharmacy name: _____ Phone: (____) _____

Primary doctor name: _____ Phone: (____) _____

Medication name/dose:	Medication treats (condition):	Medication frequency:	Notes/ questions:
		Off	
		Off	
		Off	
		Off	
		Off	
		Off	
		Off	
		Off	

Patient's Name_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I have no pain at the moment. (0)
- ☐ The pain is very mild at the moment. (1)
- ☐ The pain is moderate at the moment. (2)
- ☐ The pain is fairly severe at the moment. (3)
- ☐ The pain is very severe at the moment. (4)
- ☐ The pain is the worst imaginable at the moment. (5)

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain. (0)
- ☐ I can look after myself normally but it causes extra pain. (1)
- ☐ It is painful to look after myself and I am slow and careful. (2)
- ☐ I need some help but manage most of my personal care. (3)
- ☐ I need help every day in most aspects of self care. (4)
- ☐ I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain. (0)
- ☐ I can lift heavy weights but it gives extra pain. (1)
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- ☐ I can lift very light weights. (4)
- ☐ I cannot lift or carry anything at all. (5)

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck. (0)
- ☐ I can read as much as I want to with slight pain in my neck. (1)
- ☐ I can read as much as I want with moderate pain. (2)
- ☐ I can't read as much as I want because of moderate pain in my neck. (3)
- ☐ I can hardly read at all because of severe pain in my neck. (4)
- ☐ I cannot read at all. (5)

Section 5-Headaches

- ☐ I have no headaches at all. (0)
- ☐ I have slight headaches which come infrequently. (1)
- ☐ I have slight headaches which come frequently. (2)
- ☐ I have moderate headaches which come infrequently. (3)
- ☐ I have severe headaches which come frequently. (4)
- ☐ I have headaches almost all the time. (5)

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty. (0)
- ☐ I can concentrate fully when I want to with slight difficulty. (1)
- ☐ I have a fair degree of difficulty in concentrating when I want to. (2)
- ☐ I have a lot of difficulty in concentrating when I want to. (3)
- ☐ I have a great deal of difficulty in concentrating when I want to. (4)
- ☐ I cannot concentrate at all. (5)

Section 7—Work

- ☐ I can do as much work as I want to. (0)
- ☐ I can only do my usual work, but no more. (1)
- ☐ I can do most of my usual work, but no more. (2)
- ☐ I cannot do my usual work. (3)
- ☐ I can hardly do any work at all. (4)
- ☐ I can't do any work at all. (5)

Section 8 – Driving

- ☐ I drive my car without any neck pain. (0)
- ☐ I can drive my car as long as I want with slight pain in my neck. (1)
- ☐ I can drive my car as long as I want with moderate pain in my neck. (2)
- ☐ I can't drive my car as long as I want because of moderate pain in my neck. (3)
- ☐ I can hardly drive my car at all because of severe pain in my neck. (4)
- ☐ I can't drive my car at all. (5)

Section 9 – Sleeping

- ☐ I have no trouble sleeping. (0)
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless). (1)
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless). (2)
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless). (3)
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless). (4)
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless). (5)

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all. (0)
- ☐ I am able to engage in all my recreation activities, with some pain in my neck. (1)
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck. (2)
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- ☐ I can hardly do any recreation activities because of pain in my neck. (4)
- ☐ I can't do any recreation activities at all. (5)

Comments_____
%ADL

SportsCare Physical Therapy, PC (516) 420-1927

SportsCare Physical Therapy, PC

Date of call_____ **Appt. date/time**_____

Name_____**Date of Birth**_____**SS#**_____

Address_____**City**_____**St** **Zip**_____

Home Phone_____ **Cell Phone** _____**Work Phone** _____

Spouse_____ **Email address**_____

If Child, Parents Names_____

Employer Name/Address_____**Occupation**_____

Emergency contact_____**Phone #** _____ **Relationship to patient** _____

Referring MD **Name** _____**Town**_____

Primary Care **Name** _____ **Town**_____

Which body part are you going to be treated for? _____

Was this the result of a car accident or work related injury?_ Yes No Date of accident _____

Did you have previous physical therapy this year? Yes No If yes, how many visits_____

How did you hear about us? Family/Friend name: _____

What is your primary insurance?

Other : _____

Name_____Address_____ Phone_____

ID# _____Grp# _____ Subscriber_____DOB:_____

Subscriber SS#_____ Relationship to patient_____

What is your secondary insurance?

Other: _____

Name_____Address_____ Phone_____

ID# _____Grp# _____ Subscriber_____DOB:_____

Subscriber SS#_____ Relationship to patient_____

IF WORKERS COMP/NO FAULT INSURANCE, PLEASE FILL IN:

Name_____

Address_____Phone_____Fax_____

WCB#_____Carrier Case #_____File/Claim#_____

Policy #_____Policy Holder_____Claim Rep_____

Employer at time of accident_____

I authorize SportsCare Physical Therapy, PC to release any information to my insurance company that is necessary to expedite the payment of my claims. I understand that I am responsible for all charges not covered by my insurance including co-payments, co-insurance and deductibles. I understand that if my account is placed in collection, I am responsible for any and all fees associated with being placed into collection and legal proceedings. I also understand that it is my responsibility to obtain all necessary referrals and prescriptions when appropriate and that if said referrals are not obtained, I am responsible for the charges not covered under the referral. I authorize benefits to be paid to SportsCare Physical Therapy, PC. I authorize SportsCare Physical Therapy, PC to contact the insurance commissioner on my behalf. In the event that my workers compensation or no fault claim is denied, I will make arrangements with SportsCare Physical Therapy, PC to be paid by my private insurance and/or myself.

Patient Signature (or Signature of Parent or Guardian)_____Date_____

SPORTSCARE PHYSICAL THERAPY, PC

WORKERS COMPENSATION ASSIGNMENT OF BENEFITS & INFORMATION FORM

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

NYS WC LAW: YOU MAY NOT BE TREATED BY A CHIROPRACTOR WHILE BEING TREATED BY A PHYSICAL THERAPIST FOR THE SAME INJURY

INJURED PERSON: _____
First MI Last

DATE OF BIRTH: _____ SS#: _____ PHONE: _____

EMPLOYER AT TIME OF INJURY: _____ PHONE: _____

EMPLOYER ADDRESS: _____

INSURANCE CARRIER: _____ PHONE: _____

ADDRESS: _____

WCB CASE #: _____ CARRIER CASE #: _____

DATE OF INJURY: _____ CLAIM ADJUSTER'S NAME/PHONE: _____

ATTORNEY NAME/ADDRESS/PHONE: _____

*If treatment was rendered under Volunteer Firefighter's Benefit Law show as EMPLOYER the liable political subdivision and enter "X" here: ____

In the event I fail to prosecute the claim for Workman's Compensation for this injury or it is determined by the Workman's Compensation Board that the injury or condition is not a result of the compensable Workman's Compensation Case, I, _____, hereby agree to pay the above named provider the usual and customary fees for services rendered to the above named claimant in the above identified case.

Kindly furnish my insurance company or their representatives with all information you may have regarding my condition while under your treatment or observation, including the history obtained, physical findings, diagnosis and prognosis.

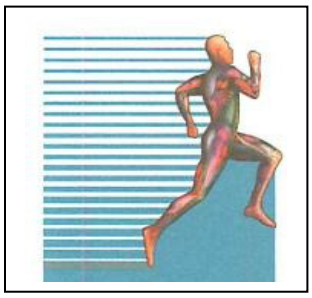
X _____
Signature of patient or guardian Date

Under the NYS Worker's Compensation Medical Treatment Guidelines, authorization must be obtained by the insurance company for you to receive treatment. Your referring physician is responsible to obtain authorization either with a C4 Auth form or an MG2 form depending on your diagnosis. Once you have finished treatment under the current authorization, you may not continue treatment until a new authorization has been granted. We will assist you and your referring physician in obtaining this authorization but it is the ultimate responsibility of the referring physician to obtain it.

During the course of your treatment, your WC insurance company may require you to attend an Independent Medical Examination (IME) performed by one of their physicians. You must attend this exam. If you do not show up for it, your insurance company may deny further benefits for treatment as of the date of that examination. It is your responsibility to inform us of the date of the exam. You may be asked to be put your treatment at our facility on "hold" while we await the results of this exam. If the physician performing the exam deems your treatment not necessary or related to your injury, your benefits will be denied and you will be responsible for any future financial obligations to this office.

I have read the above statements. I understand that I need authorization from my insurance company for treatment and will inform SportsCare Physical Therapy, PC when I am scheduled for an IME upon receiving a letter from my insurance company.

X _____
Signature of patient or guardian Date



SportsCare Physical Therapy, PC
814 Fulton Street
Farmingdale, NY 11735
516-420-1927/516-420-1952
www.sportscareptpc.com

RELEASE OF INFORMATION

I give consent to SportsCare Physical Therapy, PC to disclose or request all or any part of the patient's medical record to any person or entity which is or may be liable under a contract to the facility, family member or employer of the patient for all or part of the facilities charge, including, but not limited to physical therapy services, insurance companies, workers compensation/no fault carriers, welfare funds or the patient's employer or any New York State or Federal agency per current rules and regulations. SportsCare Physical Therapy, PC has the authority to reject any unreasonable request by an office or institution if such request might violate the patient's right to privacy. I understand that confidentiality of my medical records are protected under state and federal law and that this release gives the consent to SportsCare Physical Therapy, PC only and not to any party to whom such information is released.

Patient/Responsible Party initials: _____

ASSIGNMENT OF BENEFITS

I hereby assign and set forth SportsCare Physical Therapy, PC sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of care and treatment rendered to me or my dependent. I request that payment of authorized insurance benefits be made on my behalf directly to SportsCare Physical Therapy, PC.

Patient/Responsible Party initials: _____

CONSENT TO TREAT

I hereby request and consent to SportsCare Physical Therapy, PC to perform physical therapy treatment as prescribed by my physician and/or recommended by my physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy treatment may have some risk. I understand that I have the right to ask about these risks and have any questions answered about my condition and treatment at any time during the course of my care. I authorize the physical therapist to provide any additional care or treatment, which is deemed necessary, should during the course of treatment such action be warranted. I understand that following an initial evaluation and appropriate re-evaluations, a description of my condition/diagnosis, presenting signs and symptoms, contraindications and precautions to treatment and expected benefits of treatment will be explained to me. I have read and understand this consent and authorize SportsCare Physical Therapy, PC (including physical therapist assistants and physical therapy students in training) to administer treatment under the direction and supervision of the physical therapist.

Patient/Responsible Party initials: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SportsCare Physical Therapy, PC is committed to preserving the privacy of your personal health information. We have available a detailed notice of privacy practices which explain your rights and our obligations under the law. I acknowledge on this date that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

Patient/Responsible Party initials: _____

We value your time and as such, appointment times are at a premium. To get the best results from your treatment, it is imperative that you attend PT consistently. **If you cancel, please do so 24 hours in advance.** This will allow another patient to obtain that spot and receive their treatment. You may be subject to calling for available appointments (we will not pre book appointments) if you "No Show" (miss without calling) 3 visits. No Showing for appointments prevents someone else from receiving treatment and leaves us with an empty time in our work day. In addition, your insurance company may inquire about your attendance which may affect their determination in approving and paying for continued treatment. **Cancellations made within 24 hours of your appointment and "No Shows" will be charged a $25.00 fee.** This is neither billable nor payable by your insurance company and will be your responsibility.

Copayments are due upon arrival and prior to treatment. We accept cash, checks and credit cards (Visa, MC, Discover).

_____ _____/_____/_____
Patient/Responsible party signature Date

_____ _____/_____/_____
SCPT team member signature Date