Function First Physical Therapy, P.C.
Patient Intake Form

Patient Information:

Last Name: _____ *First Name:* _____ *Sex:* _____

Date of Birth: _____ *SS#:* _____-_____-_____

Address: _____ *City:* _____ *State:* _____

Zip Code: _____ *Work#: ( ) _____-_____ Home#: ( ) _____-_____*

Email: _____ *Mobile#: ( ) _____-_____*

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____ Domestic Partner _____

Employer's Name: _____ *Occupation:* _____

Physician's Name: _____ *Diagnosis:* _____

Injury: Work or Auto related? _____ *Allergies or Medical Precautions:* _____

Emergency Contact: _____ *Phone#: ( ) _____-_____*

Insurance Information:

Insurance Co. Name: _____ *Policy#:*_____

Address: _____ *City:* _____ *State:* _____ *Zip Code:* _____

Insured's Name: _____ *SS#:*_____-_____-_____ *Date of Birth:* _____

Address: _____ *City:* _____ *State:* _____ *Zip Code:* _____

Insured's Employer's Name: _____

I hereby accept responsibility for the cost of this examination or treatment in the event that the Insurance Company denies this claim. I hereby understand and agree to accept responsibility of the cancellation policy of this office: Giving 24 hour notice to cancel: If I am unable to comply but reschedule the appointment before and within the end of the week, no charge will be made. Otherwise a $45.00 fee will be charged for the missed session. (Please note that it is your responsibility- Insurance companies do not reimburse for missed appointments.

Patient's signature: _____

Date Signed:_____

Function First Physical Therapy, P.C.

Patient Questionnaire/ History

Name: _____ Date of Birth: _____ _____Right or _____Left handed

What is your Chief Complaint? _____

_____

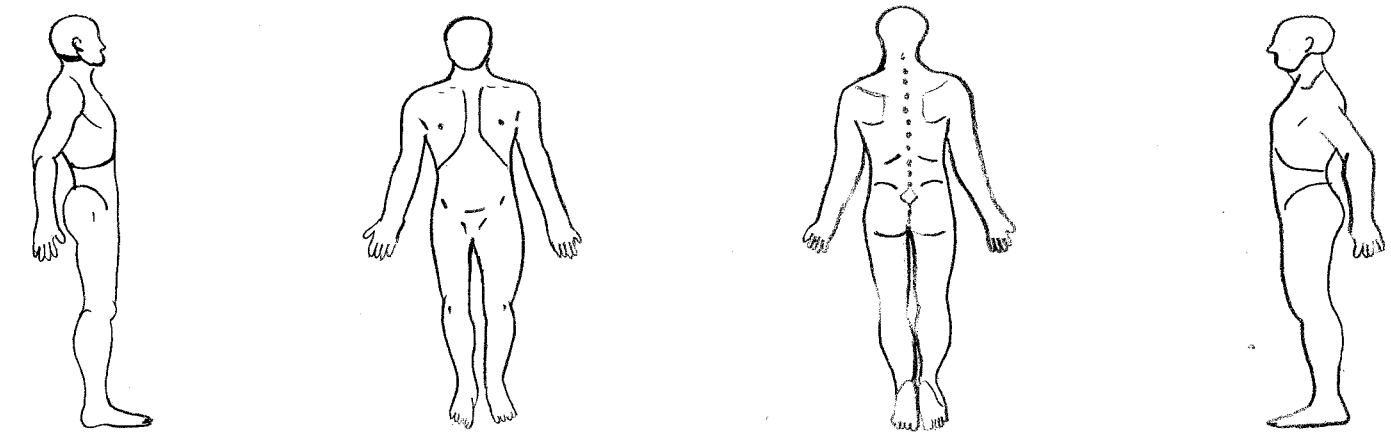
Rate your chief complaint in order of severity from worst (5) to least (1)

Pain____ Decreased Motion____ Swelling/edema____ Stiffness____ Loss of function_____

Where is your problem? Indicate on the body chart. Pain xxx: Numbness ooo: Tingling zzz:

Indicate the nature of your pain and symptoms: ___Sharp ___Dull ___Piercing___Shooting ___Aching

___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing



When and how did this problem begin?_____

_____

What makes your symptoms/ pain worse?_____

_____

What makes your symptoms/ pain lessen?_____

_____

Rate your pain on a visual scale (0-10) 0 no pain 10 excruciating pain:_____

Worst it has been_____ Past 2 to 4 weeks_____ Past 24 hours_____ At this moment_____

Are your symptoms worse in the: _____Morning _____Afternoon _____Evening _____ Inconsistent_____

Are your symptoms: _____Improving _____Worse _____Stable_____

Function First Physical Therapy
<u>Medical History</u>

*Has this problem affected your daily life or routine? Briefly describe in what ways.*_____

_____

_____

*Have you had past similar episodes of this current problem? If yes, were you treated with; (circle disciplines, which apply) Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates, General Exercise, exercise with trainer, Self medicated (Advil), ignored it, other, Did they help to alleviate your symptoms?*_____

_____

*Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results?*_____

_____

<u>Please answer the following questions:</u> *Yes* *No*

1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		
12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies?		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive devise? (cane foot orthotics)		
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) Have you ever had cancer of any sort?		
20) Do you have a history of neck or back problems?		

*Any other illness, past injuries I should be aware of?*_____
*Past surgeries___yes, ___no, give brief details:*_____
*List the medications you are currently taking (over the counter/prescription):*_____

_____

Function First Physical Therapy
<u>Social History</u>

Are you presently working? _____Yes, _____No, since:_____
_____

Physical/Emotional demands of present occupation? (High, moderate, minimal)_____
_____

Overall activity level: _____Sedentary, _____Light, _____Moderate, _____Heavy, _____Very heavy.

Sports and Exercise (Type, Frequency, Duration) _____
_____

Use of Tobacco ____Yes, ____no. Use of Alcohol ____Yes, ____No.

<u>Family medical History:</u>

Does any one in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, or Cancer?_____
_____
_____

<u>Please list 3 goals of Physical Therapy and time frames:</u>

1)_____
2)_____
3)_____

Who can we thank for this referral?
_____

Thank You for Your Patience and Valuable Time!!!

Function First Physical Therapy, P.C.

Billing Policy, Release, and Authorization

I authorize Function First Physical Therapy, P.C. to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Function First Physical Therapy, P.C. I authorize Function First Physical Therapy, P.C. to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

*Signature:*_____ *Date:*_____

Function First Physical Therapy, P.C.
119 West 23rd Street, Suite 804
New York, NY 10011
Phone (212) 691-4833 Fax (212) 691-4532

WRITTEN ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Patient: _____

I, _____ hereby acknowledge that I have received a copy of The Notice of Privacy Practices.

Signature: _____

Relationship to Patient (if patient is a minor):_____

Date: _____

Function First Physical Therapy, P.C.

119 West 23rd, Street
New York, NY 10021

Dear Valued Patient:

The staff of Function First Physical Therapy is committed to improving its facilities and service provided to you. As a result, it has become necessary to implement a $45.00 late appointment cancellation fee for any scheduled appointments that are not cancelled within 24 hours, or for NO SHOWS.

Your cooperation is greatly appreciated.

Thank you
Function First Physical Therapy

I _____ have read and agree to the above terms and conditions.

_____
Date Signed