# SportsCare Physical & Aquatic Therapy

**Medical/Physical History form**

**BACK/LOWER 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:** □ **walking** □ **negotiating obstacles** □ **moving around** □ **standing** □ **stairs** **Lifting**
***(<u>was</u> able to do)*** □ **running** □ **hopping** □ **squatting** □ **sleep** □ **shopping** □ **house keeping** □ **cooking**

**2. Functional limitation(s):** □ **walking** □ **negotiating obstacles** □ **moving around** □ **standing** □ **stairs** **Lifting**
***(<u>can't</u> do)*** □ **running** □ **hopping** □ **squatting** □ **sleep** □ **shopping** □ **house keeping** □ **cooking**

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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:** Good

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

**History of falls**: **how many?**

**Medical History:** **No known 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: _____ |

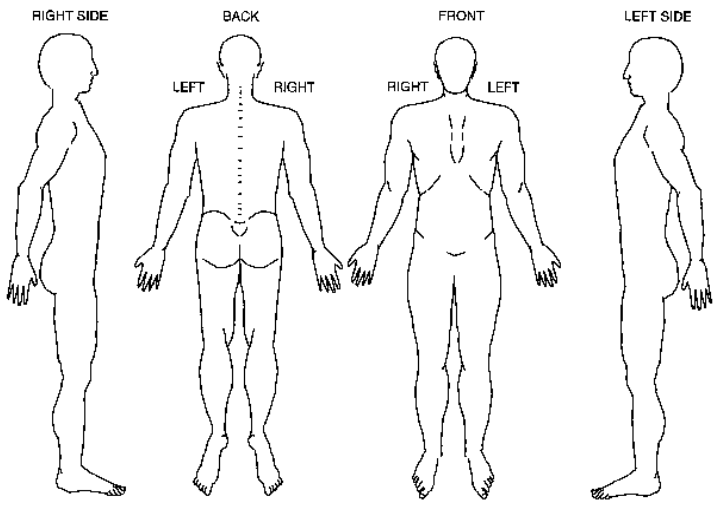
**Diagnostic Testing/Imaging:** □ **MRI** □ **CT scan** □ **X ray Findings**:

_____

**What are your goal(s) 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) >>>***




**OFFICIAL USE ONLY:**

**Total Score:** ____ **pts.;** ____ **%**

**Total Score:** ____ **pts.;** ____ **%**

Patient's Name: _____ Date: _____

# The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

**Today, *do you* or *would you* have any difficulty at all with:**

| | Activities | Extreme Difficulty or Unable to Perform Activity | Quite a Bit of Difficulty | Moderate Difficulty | A Little Bit of Difficulty | No Difficulty |
|---|---|---|---|---|---|---|
| 1 | Any of your usual work, housework, or school activities. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 2 | Your usual hobbies, re creational or sporting activities. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 3 | Getting into or out of the bath. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 4 | Walking between rooms. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 5 | Putting on your shoes or socks. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 6 | Squatting. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 7 | Lifting an object, like a bag of groceries from the floor. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 8 | Performing light activities around your home. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 9 | Performing heavy activities around your home. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 10 | Getting into or out of a car. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 11 | Walking 2 blocks. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 12 | Walking a mile. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 13 | Going up or down 10 stairs (about 1 flight of stairs). | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 14 | Standing for 1 hour. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 15 | Sitting for 1 hour. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 16 | Running on even ground. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 17 | Running on uneven ground. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 18 | Making sharp turns while running fast. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 19 | Hopping. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 20 | Rolling over in bed. | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| | **Column Totals:** | | | | | |

**Minimum Level of Detectable Change (90% Confidence): 9 points** **SCORE: _____/ 80 (fill in the blank with the sum of your responses)**

_____

**SportsCare Physical Therapy, PC (516) 420-1927**

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 | |

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ (Print patient's name), **("Assignor") hereby assign to** _____ (Print hospital or health care provider name), **("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.**

**The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on** _____ (Print accident date), **not withstanding any other agreement to the contrary.**

**This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

_____ **(Print name of Patient)**

_____ **(Signature of Patient)**

_____

_____ (Date of signature)

_____ (Address of Patient)

_____ **(Print name of Provider)**

_____ **(Signature of Provider)**

814 Fulton Street

_____

_____ (Date of signature)

Farmingdale, NY 11735

_____ (Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

# SPORTSCARE PHYSICAL THERAPY, PC

## NO FAULT INFORMATION FORM

## AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF NO FAULT CLAIM IS DISALLOWED

INJURED PERSON: _____
First MI Last

DATE OF BIRTH:_____SS#:_____ PHONE: _____

INSURANCE CARRIER: _____PHONE: _____

ADDRESS: _____

CLAIM #: _____

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

ATTORNEY NAME/ADDRESS/PHONE: _____

In the event I fail to prosecute the claim for NYS No Fault benefits for this injury or it is determined by the NF insurance company that the injury or condition is not a result of the compensable NF 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

During the course of your treatment, your NF 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 statement. I understand that I need to 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

**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_____

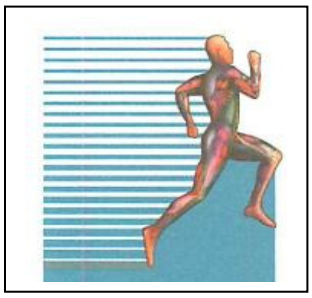
WCB#_____Carrier Case #_____File/Claim#_____

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
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