

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

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

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

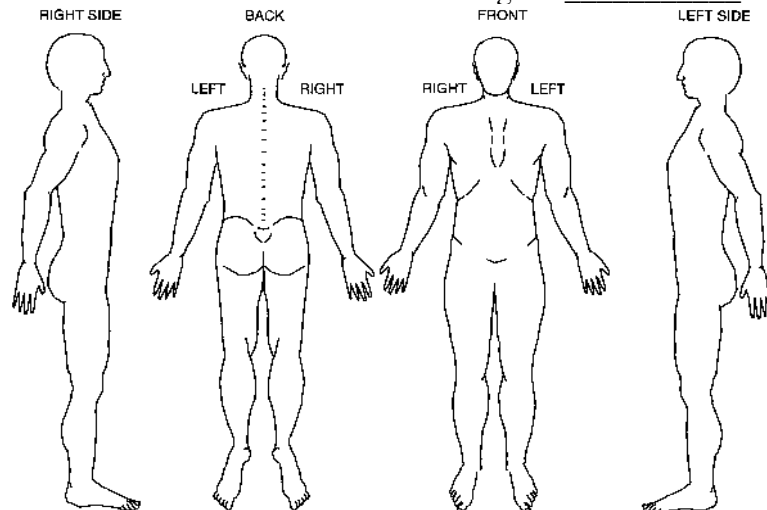
Medical History: No know significant medical history

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Strain |
| <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Obesity | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Bone fracture |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Parkinson | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Traumatic brain injury | <input type="checkbox"/> Cancer | <input type="checkbox"/> Spinal surgeries |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> 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; _____ %

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

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

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

I, _____, ("Assignor") hereby assign to _____, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
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 _____, not withstanding any other agreement
(Print accident date)
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

Farmingdale, NY 11735

(Date of signature)

(Address of Provider)

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 _____

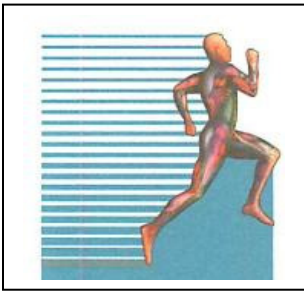
WCB# _____ Carrier Case # _____ File/Claim# _____

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