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**

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: _____

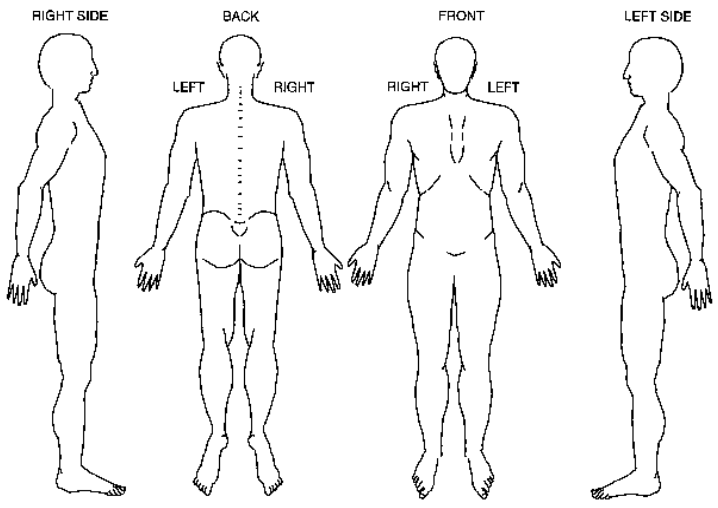
Diagnostic Testing/Imaging: □ **MRI** □ **CT scan** □ **X ray Findings**:

_____

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.;** ____ **%**

Back Index

ACN Group, Inc. Form BI-100

SportsCare Physical Therapy, PC (516) 420-1927

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

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: (Off) _____

Primary doctor name: _____ Phone: (____) _____

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

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 Off **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___Off_____

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

What is your primary insurance? Off **Other :** _____

Name_____Address_____ Phone_____

ID# _____Grp# _____ Subscriber_____DOB:_____

Subscriber SS#_____ Relationship to patient_____

What is your secondary insurance? Off **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.

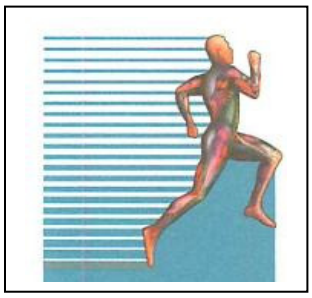
X _____
Signature of patient or guardian Date

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).

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

_____ Off _____/Off _____/Off _____
SCPT team member signature Date