

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 _____

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

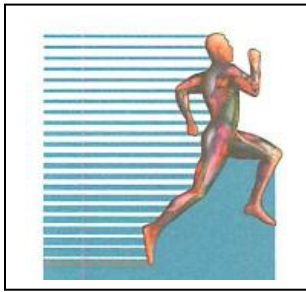
- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out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

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
(was able to do) running hopping squatting sleep shopping house keeping cooking
2. Functional limitation(s): walking negotiating obstacles moving around standing stairs Lifting
(can't 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:

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

History of falls: _____ how many? _____

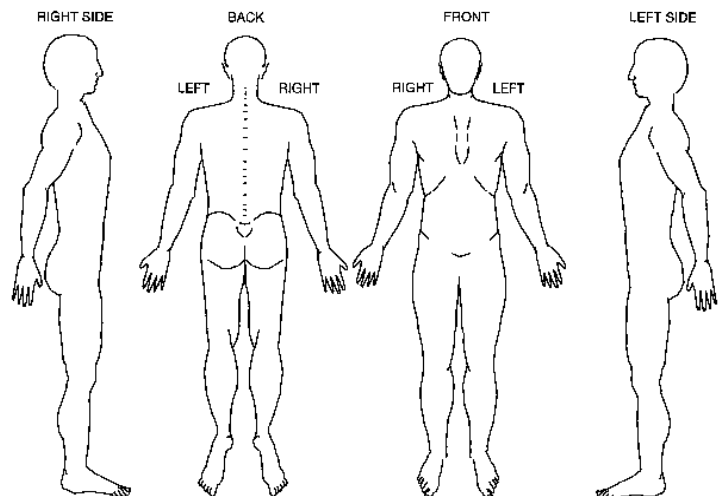
Medical History: No known significant Medical History

- | | | | |
|---|---|---|---|
| <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 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.; _____ %

