Lindenhurst Physical Therapy

Restore your quality of life with complete, hands-on, results-oriented physical therapy.

When pain, injury, lost function or impaired motion makes if difficult to enjoy life or perform necessary daily functions, it can leave you feeling frustrated, fearful, even depressed.

At **Lindenhurst Physical Therapy**, we understand. We've helped tens of thousands of people – from infants to seniors with all types of physical challenges – regain function and get back to enjoying life again. To achieve your goals, you need a physical therapist who gives you the time, one-on-one attention and hands-on care you deserve.

Lindenhurst Physical Therapy is one of the largest, most respected physical and aquatic therapy practices in the area. Our personalized approach includes advanced and proven techniques, state-of-the-art equipment, a unique saltwater aquatic therapy program and comprehensive services. All delivered at multiple locations throughout Nassau and Suffolk counties to give you the best results possible.

At **Lindenhurst Physical Therapy** you will experience the caring, compassion, and high credentialed physical therapy that can make a big difference in your life. We can relieve your pain and restore your function with state-of-the-art hands-on therapy and all the latest equipment.

256 North Wellwood Avenue, Lindenhurst, New York 11757
TEL: 631.957.7300 FAX: 631.957.5308

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information, please review it carefully. If you have any questions about this policy give us a call.

LINDENHURST PHYSICAL THERAPY LEGAL DUTY

It is the legal duty of Lindenhurst Physical Therapy to protect the confidentiality of your personal health information. We are required to provide you with this notice which outlines our policies and procedures.

USES AND DISCLOSURES OF HEALTH INFORMATION

Lindenhurst Physical Therapy, hereafter referred to as the Practice, uses your personal health information (PHI) in order to provide treatment to you, to be able to obtain payment for your treatment, to perform administrative activities within the practice, and for being able to determine the quality of care that is provided to you. PHI is all the personal information that can identify you: your name, address, telephone number, social security number, health policy number, etc. For example, we may use your PHI to call you to remind you about an appointment or to contact your insurance company for payment, speak to your Doctor about your program, or just call you into the treatment area from the waiting room.

The practice may use your PHI without prior authorization when we are required to do so by law, if there is a public health concern, if you have a communicable disease, if we believe that there is abuse or neglect, for research studies, for legal proceedings, for law enforcement, if a crime occurs in the Practice's office, if an emergency occurs, to funeral directors and coroners, for military activity and national security, and for worker's compensation.

It is policy of Lindenhurst Physical Therapy to get a signed authorization from you prior to releasing your PHI. You have the right to either agree or object to the release of your information. If you agree and sign a written authorization, you have the right to take back the authorization at a later date if you choose to. If you are not actually present, or unable to agree or disagree, to the disclosure of information, the Practice can then use it's professional judgment to decide if the disclosure is in your best interest.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to inspect and ask for a copy of your personal health information at any time. You have the right to ask us to make changes or corrections in your information. The Practice does not have to comply with your request. You have the right to file a disagreement with the Privacy Officer.

You may request a list of all the disclosures that we have made of your PHI after April 14, 2009 for any reason other than for treatment, billing, or administrative activities of the practice.

You also have the right to ask in writing that the Practice not disclose your PHI except when authorized by you, required by law or in the case of an emergency. You may also request that your PHI is not disclosed to family members or friends that may be involved in your care. The Practice will consider all such request, but is not required to agree or act on them. You have the right to have confidential information sent to you at an alternative location or by a means other than the postal service. You have the right to obtain a copy of this notice.

CONCERNS AND COMPLAINTS

If you feel that your privacy rights have been violated at any time or you do not agree with how your PHI is being disclosed, you can contact our Privacy Officer at the address listed below. The Practice will not retaliate against you for filing a complaint. You can also contact the Secretary of Health and Human Services.

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The terms of this notice may change at any time. A copy of the revised notice will be posted in the office in easily accessible areas and will be provided to you upon your request. This notice was published on January 01, 2010

Lindenhurst Physical Therapy

Patient Acknowledgement of Receipt of Privacy Practices Notice

This is to acknowledge that I have received and reviewed Lindenhurst Physical Therapy's Notice of Privacy Practices. If I have any questions, I can contact the Practice at (631) 957-7300.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

256 North Wellwood Avenue, Lindenhurst, New York 11757
TEL: 631.957.7300 FAX: 631.957.5308

Lindenhurst Physical Therapy
Consent for Treatment
(This form must be signed)

PROPOSED INTERVENTION/TREATMENT

Therapeutic Exercise
Gait Training
Modalities
Pool Therapy
Patient Education
Bed/transfer mobility
Manual Therapy
CPM
Wound Care

POSSIBLE RISK OF HARM/COMPLICATIONS

Therapeutic exercise: sore muscles and joints
Transfers and Gait Training: fall, injury from falls.
Manual Therapy: sore joints and ligaments. Rarely, dislocation, fracture, paralysis or death.
Modalities: rash, burns, skin damage: rare, burning, periosteum.
Pool Therapy: skin irritations; rare-drowning
Wound Care: skin irritations, infection, spread of infection, increased wound size.

ALTERNATIVE TO TREATMENT

Chiropractic Care
Acupuncture
Massage Therapy
No treatment, resulting in possible decrease in function

GOAL OF TREATMENT

Improve mobility
Improve function
Improve independence
Decrease pain

I was made aware of my diagnosis and prognosis by the Physical Therapist.

Date :_____

Physical Therapist:Robert Pesci, D.P.T., P.T._____

Patient Name:_____

Patient Signature:_____

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CANCELLATION AND NO-SHOW POLICY

Due to the rising cost of providing healthcare, Lindenhurst Physical Therapy now requires 24 hours' notice in the event of a cancellation. It is the Patient's responsibility, when he or she calls in, to have an alternative time in mind that will ensure that they get in the full prescribed number of treatments that week in accordance with the treatment plan. In some cases, this may not work since some forms of treatment do not work well if given two sequential days.

There is a $25.00 charge for first cancellation or No-show without proper notice. The rate will increase to $50.00 for subsequent occurrences. The patient should understand that this charge will not be covered by insurance, but will have to be paid by them personally. We schedule each patient for one-on-one time with the therapist, so that when you cancel at the last minute three people are hurt: The patient himself/herself because they are not getting the treatment they need in order to reach their treatment goals, the therapist who now has a space in their schedule since the time was reserved for that patient personally, and another patient who could have been scheduled for that treatment time if proper notice had been given.

The staff may exercise discretion in certain true emergency circumstances on a first "no-show" or improper cancellation. If the patient who is normally punctual or has some unforeseen problem, they may choose to overlook it the FIRST time. If you are unable to adhere to the treatment schedule you may need to be discharged from therapy until you are able to commit to the treatment plan.

Insurance coverage is dependent on authorizations received and must be used within a specific time frame. Failure to use your authorized visits does not ensure that you will be extended coverage.

We are here to help you achieve your maximal potential. That requires a commitment from us and you. Adhering to the treatment plan is necessary to achieve your treatment goals.

_____

Patient's **Print** Name

_____ _____

Patient's/ Guardian's **Signature** Date

LINDENHURST PHYSICAL THERAPY

Terms and Conditions

Lindenhurst Physical Therapy will bill your insurance carrier at our contracted rates. If a co-payment is due, you will be responsible for meeting your payment after each visit. Please be aware of your insurance policy provisions. If our facility is denied payment for any reason due to these provisions, you will be responsible to pay us for the denied visits. If you have any questions about which limitations apply to you, please ask the billing department or contact your insurance directly. Once your insurance benefits are exhausted, if you wish to continue physical therapy, you will be responsible for our private fee. If we decide to go out of network with your insurance, the checks will be addressed and could be mailed to you and it will be your responsibility to sign them off and either mail or deliver them to us.

In the event that this account should be placed in the hands of an outside attorney for collection, the responsible party agrees to pay all outside costs of collection, including reasonable attorneys' fees not to exceed 20% of the unpaid balance together with court costs and disbursements.

If you are unable to keep your appointment, please give the office a 24 hour cancellation notice. If 24 hour cancellation is consistently not given, we will no longer schedule appointments in advance, and we will ask that you call for your appointment on the same day you would like to come in.

I have also advised Lindenhurst Physical Therapy that my condition being treated is directly related to work and/or an on the job injury, or is due to any motor vehicle accident. Please note, when you miss or cancel an appointment, your insurance carrier will be notified of the missed appointment.

I have read the above and I agree to these terms and conditions

Signature:_____

Print Name:_____

Date:_____

LINDENHURST PHYSICAL THERAPY
ASSIGNMENT OF BENEFITS

☐ I, _____ am aware that Lindenhurst Physical Therapy is billing OUT-OF-NETWORK for provided services. I understand that my copayment will be $_____.00 a visit until further notice, or until my deductible/ out-of-pocket has been met. *Since all insurance payments will be mailed to me, I understand that I am obligated to bring and sign over all payments to Lindenhurst Physical Therapy.*

☐ I, _____ am aware that Lindenhurst Physical Therapy is billing IN-NETWORK for provided services. I understand that my copayment/ co-insurance will be $_____.00 a visit until further notice, or until my deductible/ out-of-pocket has been met.

Print Name: _____

Signature: _____ Date: _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is <u>not</u> for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

Lindenhurst Physical Therapy
256 North Wellwood Avenue
Lindenhurst, New York 11757

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE <u>BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT</u>. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM**.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: _____

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES [ ] NO [X] IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES [X] NO [ ] IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES [ ] NO [X]

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES [ ] NO [ ] NOT DETERMINABLE AT THIS TIME [X]
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: _____ THROUGH: _____

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

_____
(DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES [X] NO [ ] IF YES, describe your recommendation below:

Physical Therapy per treating Physicians recommendation

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
See attached invoice	**11757**	**Physical Therapy**		**See attached bill**
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)
Robert A. Pesci, PT, DPT	**Co-Director**	**029487-1**			X

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES [X] NO [ ]

19. ESTIMATED DURATION OF FUTURE TREATMENT

Per treating Physicians recommendation; currently 6-8 weeks

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. X (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ SIGNED _____

PATIENT PATIENT DATE

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

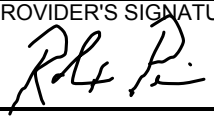
I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY 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, NOTWITHSTANDING 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

PRINT NAME (Do Not Sign) — PATIENT (Assignor)
SIGNED (Do Not Sign) — PATIENT — DATE

PRINT NAME (Do Not Sign) — PROVIDER OF HEALTH CARE SERVICE (Assignee)
SIGNED (Do Not Sign) — PROVIDER OF HEALTH CARE SERVICE — DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED?		YES	X	NO
IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE?	X	YES		NO

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.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
		**264702323**	

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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 Lindenhurst Physical Therapy , ("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)	
Robert A. Pesci, PT, DPT	
(Print name of Provider)	**(Signature of Provider)**
Lindenhurst Physical Therapy	
256 North Wellwood Avenue **Lindenhurst, New York 11757**	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

LINDENHURST PHYSICAL THERAPY

NAME: _____ DATE: _____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			
4.			

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	ALCOHOLISM	ARTHRITIS	DEPRESSION	CANCER	DIABETES	GENETIC DISEASE	HEART DISEASE	HYPERTENSION	OSTEOPOROSIS	STROKE
GRANDMOTHER (MATERNAL)	☐YES ☐NO											
GRANDFATHER (MATERNAL)	☐YES ☐NO											
GRANDMOTHER (PATERNAL)	☐YES ☐NO											
GRANDFATHER (PATERNAL)	☐YES ☐NO											
FATHER	☐YES ☐NO											
MOTHER	☐YES ☐NO											
BROTHER/ SISTER	☐YES ☐NO											
BROTHER/ SISTER	☐YES ☐NO											
OTHER	☐YES ☐NO											

Lindenhurst Physical Therapy

Medical History

Are you under a physician's care now? ☐ YES ☐ NO If Yes, explain:_____

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO If Yes, explain:_____

Have you ever had a serious neck or head injury? ☐ YES ☐ NO If Yes, explain: _____

Are you taking any medications, pills or drugs? ☐ YES ☐ NO If Yes, explain:_____

Have you ever taken Fosamax, Boriva, Actonel or any other medications containing bisphosphonates? ☐ YES ☐ NO If Yes, explain:_____

Are you on a special diet? ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO If Yes, how often:_____

Do you currently use recreational or street drugs? ☐ YES ☐ NO If Yes, explain:_____

Do you use controlled substances? ☐ YES ☐ NO

Women: are you Pregnant/Trying to get pregnant? ☐ YES ☐ NO

Taking oral contraceptives? ☐ YES ☐ NO

Nursing? ☐ YES ☐ NO

Have you had any injuries related to work? ☐ YES ☐ NO If Yes, date of accident: _____

Have you had any injuries related to an Auto Accident? ☐ YES ☐ NO If Yes, date of accident: _____

Have you had Physical Therapy before? ☐ YES ☐ NO If Yes, when: _____

Marital Status ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED ☐ DOMESTIC PARTNER

How often do you exercise? ☐ NEVER ☐ OCCASSIONALLY ☐ MODERATELY ☐ HIGH LEVEL

How often do you drink alcohol? ☐ OCCASSIONALLY ☐ < 3X/WK ☐ > 3X/WK ☐ # DRINKS/WK: _____

Do you have, or have you had any of the following?

AIDS/ HIV Positive	☐ YES ☐ NO	Cortisone Medicine	☐ YES ☐ NO	Hemophilia	☐ YES ☐ NO	Radiation Treatments	☐ YES ☐ NO
Alzehimers Disease	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO	Hepatitis A	☐ YES ☐ NO	Recent Weight loss	☐ YES ☐ NO
Anaphylaxis	☐ YES ☐ NO	Drug Addiction	☐ YES ☐ NO	Hepatitis B or C	☐ YES ☐ NO	Renal Dialysis	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Easily winded	☐ YES ☐ NO	Herpes	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Angina	☐ YES ☐ NO	Emphysema	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Rheumatism	☐ YES ☐ NO
Arthritis/ Gout	☐ YES ☐ NO	Epilepsy or Seizures	☐ YES ☐ NO	High Cholesterol	☐ YES ☐ NO	Scarlet Fever	☐ YES ☐ NO
Artificial Heart Valve	☐ YES ☐ NO	Excessive Bleeding	☐ YES ☐ NO	Hives or Rash	☐ YES ☐ NO	Shingles	☐ YES ☐ NO
Artificial Joint	☐ YES ☐ NO	Excessive Thirst	☐ YES ☐ NO	Hypoglycemia	☐ YES ☐ NO	Sickle Cell Disease	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Fainting Spells/Dizziness	☐ YES ☐ NO	Irregular Heartbeat	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Blood Disease	☐ YES ☐ NO	Frequent Cough	☐ YES ☐ NO	Kidney Problems	☐ YES ☐ NO	Spina Bifida	☐ YES ☐ NO
Blood Transfusion	☐ YES ☐ NO	Frequent Diarrhea	☐ YES ☐ NO	Leukemia	☐ YES ☐ NO	Stomach/Intestinal Disease	☐ YES ☐ NO
Breathing Problem	☐ YES ☐ NO	Frequent Headaches	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Bruise Easily	☐ YES ☐ NO	Genital Herpes	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO	Swelling of Limbs	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Lung Disease	☐ YES ☐ NO	Thyroid Disease	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	Hay Fever	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO	Tonsilitis	☐ YES ☐ NO
Chest Pains	☐ YES ☐ NO	Heart Attack/Failure	☐ YES ☐ NO	Osteoporosis	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Cold Sores/ Fever Blisters	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Pain in Jaw Joints	☐ YES ☐ NO	Tumors or Growths	☐ YES ☐ NO
Congenital Heart Disorder	☐ YES ☐ NO	Heart Pacemaker	☐ YES ☐ NO	Parathyroid Disease	☐ YES ☐ NO	Ulcers	☐ YES ☐ NO
Convulsions	☐ YES ☐ NO	Heart Trouble/Disease	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO

Have you ever had any serious illness not listed above? ☐ YES ☐ NO If Yes, explain: _____

_____

Signature: _____ Date: _____

Lindenhurst Physical Therapy

Health History Questionnaire

Your answers on this form will help Lindenhurst Physical Therapy better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained in this questionnaire are optional and will be kept strictly confidential.

ALLERGIES

List anything that you are allergic to (medications, food, etc.) and how each affects you.

Allergy	Reaction
1.	
2.	
3.	

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, i.e. vitamins and inhalers.

Drug Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Name: _____ Date: _____

LINDENHURST PHYSICAL THERAPY

PAIN ASSESSMENT

10 WORST PAIN POSSIBLE, UNBEARABLE.
Unable to do any activities due to pain.

9

8 INTENSE, DREADFUL, HORRIBLE.
Unable to do most activities because of pain.

7

6 MISERABLE, DISTRESSING.
Unable to so some activities due to pain.

5

4 NAGGING PAIN, UNCOMFORTABLE, TROUBLESOME.
Can do most activities with rest periods.

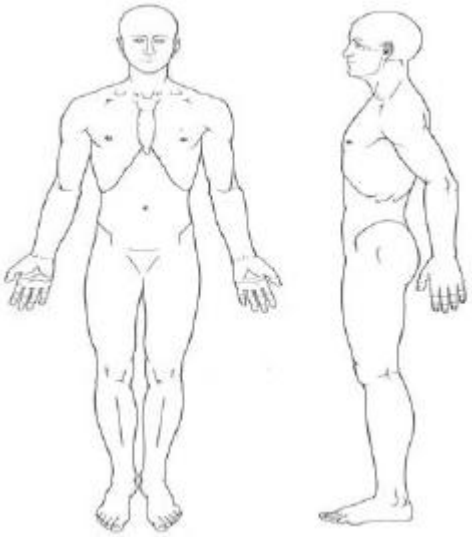
3

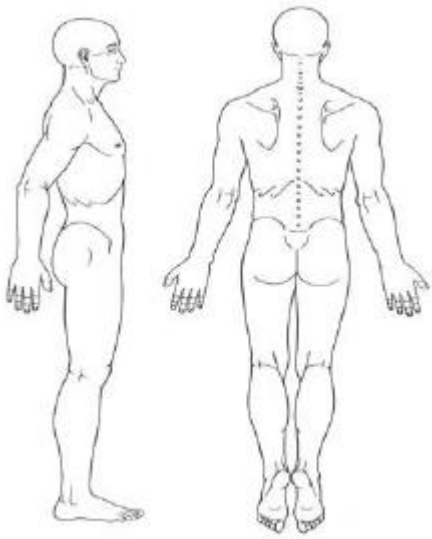
2 MILD PAIN, ANNOYING.
Pain is present, but does not limit activity

1

0 NO PAIN.

Indicate where you have pain or other symptoms





PAIN ASSESSMENT LEVEL : PRESENT: _____/10, AT BEST: _____/10, AT WORST : _____/10

1. Describe your symptoms: _____

_____

a. Onset of injury: _____

b. Mechanism of injury : _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

Signature: _____ ***Date:*** _____/_____/_____