LIHMC PHYSICAL THERAPY

Name:_____ **Address:**_____

City: _____ **State/Prov:** _____ **Zip/Postal Code:** _____

Home Phone:_____ **Cell Phone:**_____

Birth Date: _____ **Age:** _____ **Sex:** ☐ **M** ☐ **F**

Social Security # _____ **E-Mail Address:**_____

Business Employer:_____ **Circle One: Married Single Widowed Divorced Separated**

Business Phone: _____ **Type of Work:** _____

Name of Spouse: _____ **Spouse's Social Security #:** _____

Spouse's Employer: _____ **Spouse's Birthday** _____

Number of Children: _____ **Business Phone:** _____

Primary Doctor: _____ **Referred To This Office By:**_____

Name and Number of Emergency Contact:_____**Relationship:**_____

Who is Responsible For Your Bill, You and ☐Spouse ☐Workers' Comp. ☐Auto Insurance ☐Medicare ☐Medicaid ☐Personal

Health Insurance (Name) _____ **☐ Health Card (#)** _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that* LIHMC, P.C *will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to LIHMC,* P.C. *will be credited to my account on receipt. However, I clearly understand that if I suspend or terminate care, any fees for professional services rendered to me will be immediately due and payable. I also understand that I am directly and fully responsible to said doctor for any professional bills submitted for services rendered me and that this agreement holds me fully responsible for any moneys owed. In the event of non-payment, I am legally responsible for any collection fees including but not limited to, reasonable attorney fees incurred by LIHMC, PC in satisfying my debt.

I hereby authorize LIHMC,* P.C. *to treat my condition as he or she deems appropriate through use of manual therapy modalities. It is understood and agreed the amount paid to the Doctor, is for examination, and treatment only.

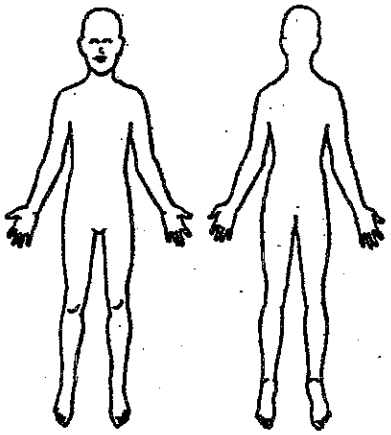
Patient's Signature_____ ***Date*** _____

Guardian or Spouse's Signature or Authorizing Care _____ ***Date*** _____

Patient Name:_____ Date:_____

Health Questionnaire

Current Complaints:



Pain Locations:
Mark location of pain with numbers in order of significance. Describe pain with corresponding numbers (i.e. "Pain Location 1") on right.

***Ask doctor for additional sheet if you have more than 2 pain locations.**

Doctor Notes:

Pain Location 1:_____

1.a. Symptoms Started: _____

1.b. How did symptoms start?

- ☐Auto Accident (complete page 3)
- ☐Work
- ☐Awoke with pain
- ☐Unknown
- ☐Work Accident (complete page 4)
- ☐Other: _____

2. Rate pain on scale: (1=none; 10=unbearable)

1 2 3 4 5 6 7 8 9 10

3. Symptoms occur:

- ☐Constantly (76-100% of day)
- ☐Frequently (51-75% of day)
- ☐Occasionally (26-50% of day)
- ☐Intermittently (0-25% of day)

4. Overall Severity:

- ☐Mild
- ☐Mild to Moderate
- ☐Moderate
- ☐Moderate to Severe
- ☐ Severe

5. Nature of symptoms:

- ☐Sharp ☐Dull ache ☐Shooting
- ☐Burning ☐Tingling ☐Numb
- ☐Radiating to _____

6. How are symptoms changing:

- ☐ Better ☐ Worse ☐ No change

7. The following make symptoms worse:

- ☐ Heat ☐ Exercise ☐ Standing
- ☐ Ice ☐ Sitting ☐ Sleeping
- ☐ Lifting ☐ Bending ☐ Walking
- ☐Sneeze/Cough/Laugh
- ☐ Other _____

8. The following makes symptoms better:

- ☐ Heat ☐ Exercise ☐ Standing
- ☐ Ice ☐ Sitting ☐ Sleeping
- ☐ Lifting ☐ Bending ☐ Walking
- ☐ Pain Medication _____
- ☐ Other _____

9. Pain interferes with:

- ☐ Work ☐ Hobbies ☐ Recreation
- ☐ Home ☐ Relationships

Pain Location 2:_____

1.a. Symptoms Started: _____

1.b. How did symptoms start?

- ☐Auto Accident (complete page 3)
- ☐Work
- ☐Awoke with pain
- ☐Unknown
- ☐Work Accident (complete page 4)
- ☐Other: _____

2. Rate pain on scale: (1=none; 10=unbearable)

1 2 3 4 5 6 7 8 9 10

3. Symptoms occur:

- ☐Constantly (76-100% of day)
- ☐Frequently (51-75% of day)
- ☐Occasionally (26-50% of day)
- ☐Intermittently (0-25% of day)

4. Overall Severity:

- ☐Mild
- ☐Mild to Moderate
- ☐Moderate
- ☐Moderate to Severe
- ☐ Severe

5. Nature of symptoms:

- ☐Sharp ☐Dull ache ☐Shooting
- ☐Burning ☐Tingling ☐Numb
- ☐Radiating to _____

6. How are symptoms changing:

- ☐ Better ☐ Worse ☐ No change

7. The following make symptoms worse:

- ☐ Heat ☐ Exercise ☐ Standing
- ☐ Ice ☐ Sitting ☐ Sleeping
- ☐ Lifting ☐ Bending ☐ Walking
- ☐Sneeze/Cough/Laugh
- ☐ Other _____

8. The following makes symptoms better:

- ☐ Heat ☐ Exercise ☐ Standing
- ☐ Ice ☐ Sitting ☐ Sleeping
- ☐ Lifting ☐ Bending ☐ Walking
- ☐ Pain Medication _____
- ☐ Other _____

9. Pain interferes with:

- ☐ Work ☐ Hobbies ☐ Recreation
- ☐ Home ☐ Relationships

Have you seen other doctors? ☐Yes ☐No If yes, who?_____
Have you had similar symptoms in the past? ☐Yes ☐No If yes, explain?_____
Have you had treatment for these symptoms? ☐Yes ☐No If yes, explain?_____

Patient Signature _____ **Date**_____

Doctor Notes:_____

Patient Health Questionnaire – page 3

Patient Name:_____ Date: _____

What type of regular exercise do you perform? ○ None ○ Light ○ Moderate ○ Strenuous

What is your height and weight? Height ___ ___ ___ (Feet Inches) Weight ___ ___ ___ (lbs.) Blood Pressure ___/___ Pulse ___

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
		Headaches			High Blood Pressure			Diabetes
		Neck Pain			Heart Attack			Excessive Thirst
		Upper Back Pain			Chest Pains			Frequent Urination
		Mid Back Pain			Stroke			Smoking/Use Tobacco
		Low Back Pain			Angina			Drug/Alcohol Dependence
		Shoulder Pain			Kidney Stones			Allergies
		Elbow/Upper Arm Pain			Kidney Disorders			Depression
		Wrist Pain			Bladder Infection			Systemic Lupus
		Hand Pain			Painful Urination			Epilepsy
		Hip/Upper Leg Pain			Loss of Bladder Control			Dermatitis/Eczema/Rash
		Knee/Lower Leg Pain			Prostate Problems			HIV / AIDS
		Ankle/Foot Pain			Abnormal Weight Change			Chronic Sinusitis
		Jaw Pain			Loss of Appetite	Females Only		
		Joint Swelling/ Stiffness			Abdominal Pain			Birth Control Pills
		Arthritis			Ulcer			Hormonal Replacement
		Rheumatoid Arthritis			Hepatitis			Pregnancy
		General Fatigue			Liver/Gall Bladder Disorder	Other Health Problems / Issues		
		Muscular Uncoordination			Cancer			Alcohol use-Social
		Visual Disturbances			Tumor			Alcohol-None
		Dizziness			Asthma			

Indicate if an immediate family member has had any of the following: (include family member)

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer___ ○ Lupus ○ _____

List all prescription and over-the-counter medications and nutritional/herbal supplements you are taking and their dosages:

_____ _____ _____

_____ _____ _____

Are you allergic to any medications (please list): _____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient's Signature _____ **Date:**_____ **Doctor's Signature** _____ **Date:**_____

Consent For Use And/Or Disclosure Of Protected Health Information To Carry Out Treatment, Payment And/Or Healthcare Operations

Through the use of this consent form Long Island Home Medical Care (referred to as the or this "office") is notifying you and agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations.

2. If you do not consent to the above use and/or disclosure, Federal Rules do not require or oblige this office/practice to treat you in the absence of your consent.

3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or healthcare operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.

4. The following appointment reminders will be used by this office: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

5. This office reserves the right to change its privacy practices that are described in the above-referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.

6. You have a right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations.

7. This office is not required to agree to any restrictions on your health information that you have requested.

8. If this office agrees to a requested restriction, then the restriction will be binding on this office/practice.

9. This consent is valid for seven years. You have the right to revoke this consent, in writing, at any time for all future transactions with the understanding that any revocation will not apply to the extent that this office/practice has already taken action in reliance of a previously signed consent.

10. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.

11. You must sign and date all consents and authorizations requested to which you agree.

I have read and understand the foregoing notice,and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Patient/Individual (Please Print)	Signature of Patient/Individual
Signature of Legal Representative	Relationship to Patient
Date Signed	Witness