



North Island  
PHYSICAL THERAPY, PC

2500 Nesconset Highway Bldg 22B Stony Brook, NY 11790  
Tel: 631-751-7988 • Fax: 631-751-7989  
Web: <http://www.northislandpt.com>  
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### Patient Information Form

Name \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Work phone # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Work phone # \_\_\_\_\_

Nearest relative not living with you \_\_\_\_\_ Phone # \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist (TMJ only) \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Phone # \_\_\_\_\_

Who is financially responsible for this bill? \_\_\_\_\_

Have you had physical therapy this year? \_\_\_\_\_ how many visits? \_\_\_\_\_

**Please complete one of the following insurance information: General, No Fault, or Workman's Compensation**

**General Insurance Information:**

Primary Insurance Company \_\_\_\_\_  
Billing address \_\_\_\_\_  
ID # \_\_\_\_\_ Phone number \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_  
ID # \_\_\_\_\_

**No Fault:**

Insurance Company Name & Address \_\_\_\_\_  
\_\_\_\_\_  
Adjuster's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Case/Claim # \_\_\_\_\_ Date of injury \_\_\_\_\_

**Workman's Compensation:**

Insurance Company Name & Address \_\_\_\_\_  
\_\_\_\_\_  
Adjuster's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Case/Claim # \_\_\_\_\_ Date of Injury \_\_\_\_\_  
Employer's name \_\_\_\_\_

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status of the above information.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Parent (if minor) \_\_\_\_\_ Date \_\_\_\_\_

  
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## Medical History Questionnaire Form

Patient Name:		Date:
Marital Status:	Age:	# of Children
Occupation:		

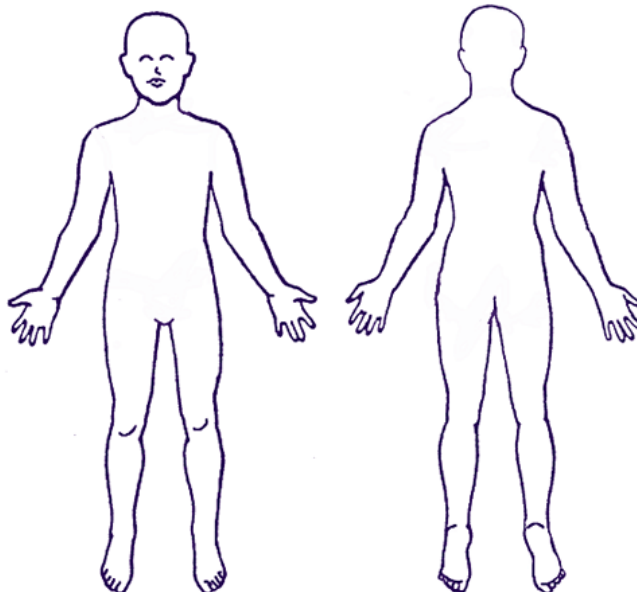
PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. THE THERAPIST WILL REVIEW YOUR RESPONSES WITH YOU.

Height:	Current Weight:	Gain/Loss Over Past Year:
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Present Condition, Pain or Tension:

1. Please shade in the area or areas where you are experiencing pain/symptoms. Use the following descriptions of pain to indicate the type of pain in each area that you shade by placing the letter from the chart below on each area shaded.

A. Severe	E. Weakness	I. Burning
B. Moderate	F. Sharp	J. Stabbing
C. Mild	G. Dull	K. Achy
D. Numbness/Tingling	H. Throbbing	L. Radiating





**Your physical therapist must have a thorough understanding of your medical history to treat you to the best of their ability. Please Check Yes or No for ALL of the following.**

Do you currently have, or have you had in the past:

- High Blood Pressure  Yes  No
- High Cholesterol  Yes  No
- Heart Disease  Yes  No
- Congestive Heart Failure  Yes  No
- Heart Attack  Yes  No
- Coronary Bypass Surgery  Yes (if yes, list date(s) \_\_\_\_\_)  No
- Pacemaker  Yes (if yes, list date(s) \_\_\_\_\_)  No
- Coronary Artery Stents  Yes (if yes, list date(s) \_\_\_\_\_)  No
- Peripheral Artery Disease  Yes  No
- History of Blood clots  Yes  No
- Do you take Coumadin (Blood thinners) regularly  Yes  No
- Emphysema  Yes  No
- COPD  Yes  No
- Asthma  Yes  No
- History of pneumonia  Yes  No
- Diabetes  Yes  No
  - Do you inject insulin  Yes  No
- Blood Sugar disorders  Yes  No
- Cancer  Yes (if yes, list date(s) \_\_\_\_\_)  No
  - Type/Location \_\_\_\_\_
  - Are you currently undergoing (please circle) Chemotherapy or Radiation therapy
- Stroke  Yes (if yes, list date(s) \_\_\_\_\_)  No
- Head Injury  Yes (if yes, list date(s) \_\_\_\_\_)  No
- Seizure Disorders  Yes  No
- Parkinsons Disease  Yes  No
- Peripheral Neuropathy  Yes  No
- Frequent headaches  Yes  No
  - Please circle frequency: Daily Weekly Monthly
- Migraine headaches  Yes  No
- Lupus  Yes  No
- Irritable Bowel Syndrome  Yes  No
- Crohns Disease/Ulcerative colitis  Yes  No
- Fibromyalgia  Yes  No
- Disorders which affect your immune system  Yes  No
- Rheumatoid Arthritis  Yes  No
  - Which joints are affected \_\_\_\_\_

Osteo-Arthritis  Yes  No

-Which joints are affected \_\_\_\_\_

Total Hip Replacement  Yes (if yes, list date(s)\_\_\_\_\_)  No

Total Knee Replacement  Yes (if yes, list date(s)\_\_\_\_\_)  No

Osteoporosis/Osteopenia (Brittle Bone Disease)  Yes  No

- Date of last bone density scan \_\_\_\_\_

History of motor vehicle accidents with injuries  Yes(if yes list date(s))\_\_\_\_\_  No

- Type of injuries \_\_\_\_\_

History of broken bones  Yes (if yes list date(s)\_\_\_\_\_)  No

- Location \_\_\_\_\_

History of injury to your joints  Yes (if yes list date(s)\_\_\_\_\_)  No

- Location \_\_\_\_\_

Neck Pain  Yes  No

Low back pain  Yes  No

Sciatica  Yes  No

Herniated Disks / Pinched Nerves  Yes  No

History of Scoliosis (Curvature of the Spine)  Yes  No

Disorders that affect your mood  Yes  No

Sleep Disorders  Yes  No

Pain at night  Yes  No

Are you pregnant, or is there any possibility you could be pregnant?  Yes  No

Please List ALL other medical conditions you may have which are not included in the above list.

Are you currently under the care of physician, psychiatrist, or other health care professional other than the one who prescribed you to physical therapy?

Yes \_\_\_\_\_  No

Please List ALL Surgeries you have had, including dates and locations.

Please List ALL medications you are currently taking.

Please list ALL allergies you have.

**I certify that the above information is accurate to the best of my knowledge.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
Reviewed by: Physical Therapist