NORTH ISLAND
Physical Therapy

Medical History Questionnaire Form

Patient Name:	Date:
Occupation:	Age:

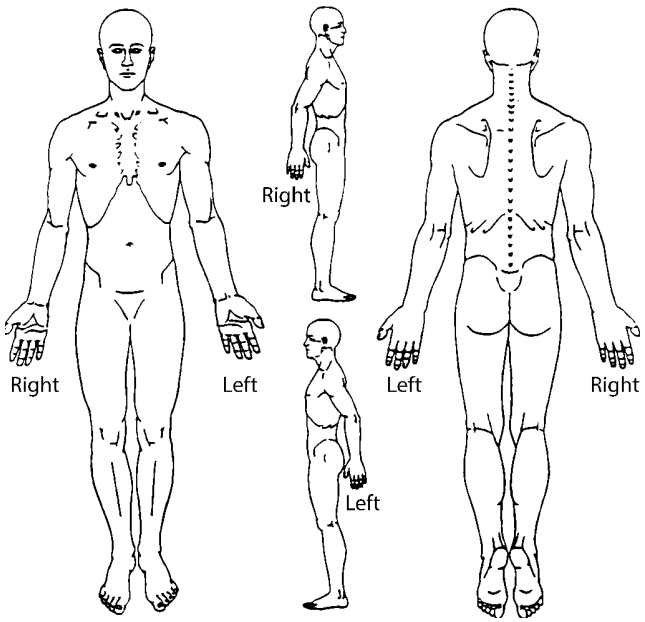
PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. THE THERAPIST WILL REVIEW YOUR RESPONSES WITH YOU.

Height:	Current Weight:	Gain/Loss Over Past Year:

Present Condition, Pain or Tension:

1. Please mark on diagram and list symptoms below that you are experiencing and rate each on a scale of 0 to 10. (Key: 0 = no pain and 10 = worst pain ever experienced)

Symptoms	Severity
A. _____	0 2 3 4 5 6 7 8 9 10
B. _____	0 2 3 4 5 6 7 8 9 10



2. Since its initiation, has the pain changed? _____

3. How often do you experience the pain? _____

4. What do you think initially caused your pain? _____

5. Have you ever had these symptoms before? If yes, when: _____

North Island Physical Therapy Medical History Questionnaire

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

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

Cardiac problems such as Heart disease, High Blood Pressure, Congestive Heart Failure, Pacemaker, Heart Attack, Coronary Bypass Surgery, etc.	Yes	No
Peripheral Artery Disease	Yes	No
History of Blood clots	Yes	No
- Do you taken Coumadin (Blood thinners) regularly	Yes	No
Breathing problems, such as COPD, Asthma, Pneumonia or Emphysema	Yes	No
Diabetes	Yes	No
- Do you inject insulin	Yes	No
Cancer	Yes	No
-Type/Location/Year Diagnosed/Treatment _____		
Neurological disorders, such as Parkinson's disease, Multiple Sclerosis, seizure disorder, history of a Stroke, etc.	Yes	No
Head Injury (if yes, list date(s)_____,	Yes	No
Frequent headaches	Yes	No
-Please circle frequency: Daily, Weekly, Monthly		
Peripheral Neuropathy	Yes	No
Autoimmune disorders, such as Rheumatoid Arthritis, Lupus, Sarcoidosis, Crohn's disease, etc.	Yes	No
Osteoporosis/Osteopenia	Yes	No
History of Orthopedic conditions such as osteoarthritis, broken bones, joint injuries, herniated discs or neck/low back pain (if yes, list below)	Yes	No
-Location _____		
Disorders that affect your mood	Yes	No
Pain at night	Yes	No
Are you pregnant, or could you be pregnant	Yes	No

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

_____

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

_____

Please List **ALL** medications you are currently taking.

_____

Please list **ANY** allergies you have.

_____

_____

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

Have you ever had physical therapy previous to this occasion? If yes, please explain for what problem, how much therapy and when:

_____

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

_____ Patient Signature

_____ Physical Therapist Signature

NORTH ISLAND
Physical Therapy

Patient Information Form

Name_____ Date of Birth_____

Home Phone #_____ Cell Phone #_____

Please check the preferred number to be reached at: Home ☐ Cell ☐

Email Address_____

Address_____ City_____ Zip_____

Emergency Contact/Relationship_____ Phone#_____

Primary Insurance_____ ID#/Claim #_____

Insured's Name_____ Relationship_____

Secondary Insurance_____ID#/Claim#_____

Insured's Name_____Relationship_____

Whom may we thank for referring you?_____

If the patient is under 18: Who is financially responsible for this bill?

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge.

Signature (Parent or guardian if under 18) Date

Patient Appointment Cancellation Policy

Your adherence to the recommended number of treatments is a vital component of your progress with your physical therapy. Therefore, it is necessary for you to conform to our office policy regarding cancellations and missed appointments.

With the exceptions of illness or serious emergencies, it is expected that you keep all of your scheduled appointments. If you do need to reschedule, we require 24 hours notice. In that case, please call our office as early as possible to reschedule your appointment.

In the case of a missed or cancelled appointment, you will be charged a $25 cancellation fee.

In cases of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your referring physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We greatly appreciate your cooperation.

Release of Information

NORTH ISLAND PHYSICAL THERAPY may disclose all or any part of the patient's medical record to any person or corporation which is or may be liable under a contract to the facility for all or part of the facility's charge, including, but not limited to insurance companies, Workmen's Compensation/No-fault carries, welfare funds, the patient's employer, and New York State or Federal agency per current rules and regulations. NORTH ISLAND PHYSICAL THERAPY has the authority to reject any unreasonable request by an office or institution if such privacy request might violate the patient's right to privacy.

I have read and I understand both of these policies.

Signature (Parent or guardian if under 18) Date

I have been presented with a copy of NORTH ISLAND PHYSICAL THERAPY'S Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I authorize NIPT to leave detailed messages on my answering machine and I understand the contents of the notice.

Signature (Parent or guardian if under 18) Date