## LONG ISLAND UNIVERSITY CENTER FOR PHYSICAL REHABILITATION

### **GENERAL INFORMATION**

Name				Date
Last	First		MI	
Address				
City		State		Zip
Telephone: Cell ()	Home (	)	Work (	)
Email				
DOB				
MEDICAL INFORMATION				
Diagnosis				
Referring Physician				
In case of emergency, please	notify			
Relationship	Telephone V	Vork ()	Home (	)
PHYSICAL THERAPY GOALS				
Please list goals you would lik	e to achieve through rehab	ilitation. Please be	specific.	
2 3.				
uses and disclosures of m	Notice of Privacy Practices v y protected health informa respect to my protected h	tion that may be m		
	reserves the right to chang I protected health informat Practices on request.		· ·	
			_	
Parent/Guardian Signatui	·e:		D	ate

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# **Subjective Medical History**

Patient Name: Last	First	Date
Date of Birth	AgeDate of Last Dr. Visit	Current Weight
	Have you had or ever been tol	d you had:
General	Nose/Throat	Respiratory
□ Weight loss	□ Nose bleeds	□ Sputum production
□ Loss of appetite	□ Sore Throat	□ Coughing up blood
□ Neck swelling/lumps	□ Trouble swallowing	□ Emphysema
☐ Frequent headaches	Musculoskeletal	□ Asthma
□ Daytime Fatigue	□ Weakness	□ Bronchitis
□ Always hungry	□ Painful Feet	□ Wheezing/gasping
□ Lightheadedness	□ Joint pain/swelling	□ Pneumonia
□ Fever/chills	□ Back or shoulder pain	Neurological
☐ Excessive sweating	☐ Arthritis	□ Head injury
□ Insomnia	Gastrointestinal	□ Loss of consciousness
Metabolic/Endocrine	□ Indigestion	☐ Dizzy spells/ fainting
□ Diabetes	□ Ulcer history	□ Numbness/tingling
☐ Hot/cold intolerance	□ Vomiting/nausea	□ Tremors
☐ High cholesterol	□ Intestinal disease	□Seizures
□ Gout	□ Abdominal pain	Psychiatric
Allergies	□ Blood in stools	□ Depression
□ Food	□ Hernia	□ Anxiety
□ Medications	□ Liver Disease	□ Treatment
□ Seasonal	□ Frequent diarrhea	□ Nervous/worry
□ Bee Sting	□ Gall bladder disease	Hematologic
□ Hay Fewer	□ Pancreatitis	□ Anemia
_ Latex	□ Stones	□Easy bruising/bleeding
Skin	□ Rectal bleeding	□ Leukemia
□ Rash	□ Pain in rectum	Renal/urinary
□ Itching	Peripheral Vascular	□ Kidney disease
☐ Mole Changes	□ Reynaud's	☐ Bladder inflections
□ Tumors/cysts	☐ Calf pain w/ walking	□ Frequent urination
☐ Unusual hair growth/loss	S Cardiopulmonary	□ Night time urination
☐ Surgical scar(s)	☐ High blood pressure	□ Releasing urine when
Eyes	□ Chest pain 9angina)	coughing/sneezing
□ Blurry vision	□ Palpitations	☐ Blood in urine
□ Double vision	□ Coughing up blood	□ Burning with
□ Eye pain	□ Shortness of breath	urination
□ Blind spots	<ul> <li>Shortness of breath at</li> </ul>	t night 🗆 Incontinence
□ Infections	<ul> <li>Swollen feet or ankles</li> </ul>	Genitoreproductive
□ Cataracts	<ul> <li>Irregular heart beat</li> </ul>	□ Sexual dysfunction
□ Glaucoma	□ Heart attack	□ Infertility
<ul><li>Wear glasses/contacts</li></ul>	Breast	□ Infections
Mouth	<ul> <li>Lump or pain in breast</li> </ul>	ts Women only:
<ul><li>Teeth problems</li></ul>	<ul> <li>No Annual breast exar</li> </ul>	m □ No Annual OB/GYN
□ Jaw pain	□ Discharge	□ Trouble with your
□ Bleeding gums	Ear	period
☐ Swelling on gum or jaws	□ Hearing loss/ Infection	n □ Endometriosis
	□ Vertigo/ Dizziness	□C-Section delivery
		<ul> <li>Currently pregnant</li> </ul>

# **Physical Therapy Pre-Exam Questionnaire**

In order to evaluate your condition fully, please be as accurate as possible. Thank You.

1. 2.	What is your age? What is your gender?	Male	 Female	
	What is your occupation?			
	Are you working now?	Yes	No	
4. 5.	Have you had physical therapy before? Where is your pain/problem?	Yes	No	
	What caused your pain or problem?			
7.	Approximately when did it start?	/_	/20	
8.	Is it getting worse, better, or staying the same?			
9. 10	Have you ever had this pain/problem before? Is your pain constant (never goes away)?	Yes Yes	No No	
	On the scale below circle your worst pain level in the			
		·	,	
	Mild Moderate	Severe	(3)4	dis dis
	0123456789.	10		7
	Please indicate on body chart the location of your pa	ain or		
	symptoms:			
				<i>})                                    </i>
			\W/ \\\\	
12	Are you taking any medications for this pain (proble	m J		
12.	Are you taking any medications for this pain/problem	m:		
	Yes No			
	If yes, what and does it help?			
42	Assessed to the second second three flexibilities		W	NI.
13.	Are any of your usual everyday activities affected? If yes, describe how.		Yes	No
	, ,			
14.	List all past surgeries with dates:			
15.	List all medical conditions you have (or were told yo	ou have)?	)	
	,	,		
	Patient Name:			
	Signature:		Date:	

## Important Company Policies for a Successful Relationship

pottom.	
LATE POLICY "10-MINUTES"  Being late by more than 10 minutes will require you to either reschedule or wait for the next a opening. There are no guarantees since openings due to cancellations are unpredictable. We do n appointment overlap because this undeservedly compromises the care of another patient.	
24-Hour Advance Notice Fee  If you wish to change or cancel an appointment we require a minimum 24-hour advance notice. A less will result in a \$25 fee charged to your account. Advance notice allows someone else (who needs to reserve it in place of you. Please be courteous and responsible. Thank you.	-
Copays/Co insurances and Deductibles are due upon arrival  If you happen to forget your wallet or checkbook we may still be able to see you upon completic "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows your appointment.	
Patient Financial Responsibility  It is understood that the patient, or payor, is responsible for your yearly deductible amount, any perstipulated by your particular plan, and any balance not covered by your insurance carrier. If the incarrier denies payment, the patient or payor will be responsible for those fees.	_
Assignment of Benefits  If reimbursing for PT services are mailed directly to the subscriber, the member or subscriber w payment to Long Island University for the full amount of the check.	ill make
No-show are bad  If you fail to show for an appointment without notice all future appointments will be removed and a assessed to your account. Yu may re-schedule appointments again on a "first come, first serve basis".	
Cell phones must be shut OFF or silent  We realize emergencies may arise and therefore allow you to carry your cell phone during you however, please be courteous and set to silent mode or turn off. Thank you.	session,
Children requiring supervision are NOT allowed to attend sessions with you  You may not bring children who require supervision with you to your appointment. If y our child of require supervision and is capable of waiting for you quietly then you may bring them. If any disturt caused to other patients or staff members you may be asked to terminate your session early and a your child.	bance is
Patient/Guardian Signature Date	

#### **Important Notice from the Federal Government**

It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments...even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's—Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202-619-1343, by fax: 202-260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202-619-0089

Release of medical record	
treatment in order to accurately and efficie	, hereby authorize Long Island University Center for Physical realth information acquired in the course of my evaluation and ently process my insurance claims. I have read and understand the ation and Policy form. I attest that II information provided by me is
Patient/Guardian Signature	Dato