east end physical therapy | manual + sports physical therapy

PATIENT HISTORY FORM

Name: ______________________________________ Weight: _______ Height: _______

Social Security Number: ______________________ Date of Birth: ___________________

Mailing Address: ____________________________ Phone: ________________________

____ Email: ________________________

____

Emergency Contact Name: ____________________ Number: _______________________

Gender: M / F

Pacemaker: Yes / No

Smoker: Yes / No

Pregnant: Yes / No

Occupation:

Past Surgeries (list & date): ____

____

Current Medications (prescription, over-the-counter): ______________________

____

____

Past Medical History: Have you ever been told you have any of the following?

Condition	Yes	No	Condition	Yes	No
Cancer	Yes	No	Blood Clots	Yes	No
Heart Problems	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Lung Problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis/Osteopenia	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Others ______________________		

Currently: Are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	
Numbness/tingling	Changes in appetite	Difficulty swallowing	Pelvic pain
Depression	Shortness of breath	Night pain	Headaches
Dizziness	Nausea/vomiting	Changes in bowel or bladder functions	

Therapist Signature: ____ Date: _____________

Name: ____ Date: ____________________

Body Chart:

Mark the areas where you feel your symptoms

On the scale below, circle the number which best represents the average level of pain you have experienced over the last 48 hours:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain Imaginable

Current History:

What date (approximately) did your present symptoms start? ______________________________

How? (gradually, suddenly, injury) ____

How have your symptoms changed? Getting better about the same getting worse

What makes your symptoms better? ____

What makes your symptoms worse? ____

Have you had an x-ray, MRI, or other testing for this problem? No / Yes (specify) _________________

What treatments have you received for this problem so far? ____________________________

How did you hear about us? ____

Manual + Sports PT Southampton
167 S Main Street
Southampton NY 11968
(631) 283 - 4190

East End Physical Therapy
300 Pantigo Place - Suite 112
East Hampton NY 11937
(631) 329 - 1828

Manual + Sports PT Sag Harbor
60A Bay Street
Sag Harbor NY 11963
(631) 725-4450

www.mspthamptons.com

Assignment of Benefits

I have coverage with the above insurance company, and assign directly to Manual & Sports Physical Therapy all medical benefits, if any; otherwise payable by self, for services rendered. I understand I am fully responsible for all charges, whether or not paid by my insurance company. I authorize Manual & Sports Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Per New York state law, I understand it is my responsibility to provide Manual & Sports Physical Therapy with an up to date prescription from my referring physician, thus I will not be seen for physical therapy with an out of date prescription.

I have read the notice of privacy practice and am informed of my rights and the practices and legal duties with regard to my protected health information.

PLEASE NOTE CO PAYS ARE DUE AT EACH VISIT.

Cancellation and no show Policy

Our policy requires that patients give a 24-hour notice for all appointment cancellations. This policy is in place to maximize your progress and minimize loss of appointment availability for other patients. Cancellations with less than 24-hour notice and no shows for scheduled appointments will be subjected and billed a fee for $40.00 for each missed appointment. This is not covered by your insurance company.

Print Name: ____ Date: ______________

Patient/Guardian Signature: ____________________________________

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