WOODSTOCK
PHYSICAL THERAPY

Handing you back your full physical potential

Patient Information Worksheet

Name______________________________________ Today's Date ______/______/_________

Address ______________________________ Date of Birth _____/_____/_________Age________

City, State, Zip ____

Telephone: Home ____________________ Work _____________________ Cell ______________________

Email: ____________________________ Emergency Contact: ____________________________________

Alternate Recipient for Statements ____

Physician Information:

Referring Physician ___________________________ Primary Care Physician ___________________________

Date of Injury ______/______/_______Have you had surgery? Yes ____ Date ______/______/_________ No _____

Have you had Physical Therapy this calendar year? Yes _____How many visits? __________ No _____

How did you hear about Woodstock Physical Therapy? ____

Workers' Comp/ No Fault Information (if applicable):

Insurance Company ______________________________ Claim #____________________________________

Adjustor's Name _______________________________Adjustor's Phone #_________________________

Address____

Date of Accident ______/______/________ State where accident occurred _______________

Attorney's Name ___________________________ Attorney's Phone #_____________________________

Address____

Employer ____

Insurance Information:

Primary Insurance __________________________Secondary Insurance ______________________________

Policy Holder ___________________________ Policy Holder ________________________________

ID Number ______________________________ ID Number __________________________________

(Relationship to Policy Holder ______________) (Relationship to Policy Holder ______________)

Copay_____________________________ Copay_____________________________

845-679-9767 • Fax 679-2604 • Mail@WoodstockPhysicalTherapy.com
2568 Route 212 • PO Box 1235 • Woodstock, New York 12498
www.WoodstockPhysicalTherapy.com

Woodstock Physical Therapy
Medical History Intake Form

Name______________________________ **Date**____/____/____

What problem brings you here today? ____
How and when did it start? ____
What makes it *worse*? ____
What makes it *better*? ____
What do you want to accomplish from today's visit?

What treatments have you had for this problem? Physical Therapy, Chiropractic, Massage, Injections, Acupuncture			**What diagnostic tests have you had for this problem?** (X-ray, EMG, MRI, Bone scan, etc)
Is this a Worker's Compensation or No Fault Claim?	Yes	No	

Please *circle the numbers* below to indicate the range of discomfort you've been feeling lately.

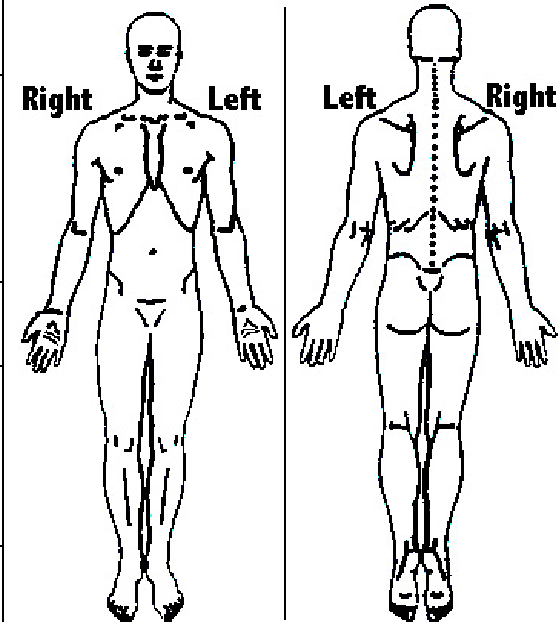
No Pain ———————————————— Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like:
Sharp, Shooting, Dull ache, Burning, Stabbing, Numbness, Tingling, Cramping, Tightness
Frequency of Pain: Constant (76-100%), Frequent (51-75%), Occasional (26-50%), Intermittent (25% or less)

Medications: Please list *ALL* medications including Prescription, over-the-counter (i.e. Advil), and Supplements/Vitamins	
Medical/Surgical History: (Circle all that apply): Diabetes, Cancer, Heart attack, Arthritis, High Blood Pressure, Stroke or TIA, Asthma, Tumor, Hepatitis, Epilepsy, All Surgeries, Broken Bones, Accidents, Other Injuries	**Other:**
Family History: (Cancer, Arthritis, Osteoporosis)	
Hospitalization History	
What is your Occupation?	

Please draw the location of your discomfort



Employment status:	Full-time	Part-time	Light Duty	Off Duty due to injury	Full-time Parent	Not working	Retired

Physical requirements of your occupation or recreation:
Prolonged sitting, prolonged standing, Phone, Computer, Lifting, Travel, Driving, Gardening, Childcare, Other:

Does this injury limit any of your regular activities?
Sleep, Grooming, Bathing, Chores, Driving, Daily Exercise Program, Work-related tasks, Other:

What type of exercise do you do?

Do you have any of the following symptoms:

♥	Dizziness, numbness, tingling	Yes	No
♥	Night pain, difficulty sleeping	Yes	No
♥	Vision change, double vision	Yes	No
♥	Chest pain, palpitations	Yes	No
♥	Depression	Yes	No

♥	Headaches	Yes	No
♥	Shortness of breathe	Yes	No
♥	Nausea	Yes	No

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ASSIGNMENT OF BENEFITS
AND RELEASE OF MEDICAL INFORMATION

I request that payment of authorized benefits be made on my behalf to **Woodstock Physical Therapy** for services furnished to me by the provider/therapist. I authorize any holder of medical information about me to release to **Woodstock Physical Therapy** any information needed to determine these benefits or the benefits payable for related services.

____
Name of Patient

____ ________________________
Signature of Patient Date

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WAIVER OF LIABILITY AND PRIVACY PRACTICES ACKNOWLEDGEMENT

As a service to our clients, we do accept most insurance and will file claims directly to them. However, we do ask that our clients take responsibility for finding out the full extent of their individual policies, such as:

- The annual deductible
- Copay per visit
- Number of visits allowed per year
- Limitations, if any, of treatment duration
- Whether preauthorization is needed
- Whether or not we are participating providers in your particular plan

I, _____________________________, fully understand my responsibility in finding out the full extent of my insurance benefits. Knowing this, I have instructed **Woodstock Physical Therapy** to proceed with physical therapy services. I agree to pay my yearly deductible and my copay per visit. In addition, if my insurance company decides to reduce/deny payment for any physical therapy service, I will assume full responsibility for payment.

I agree to provide **24-hour** cancellation notice. **If I fail to do so, I agree to pay a $40 missed appointment fee**.

I have received the **Notice of Privacy Practices** and I have been provided an opportunity to review it.

My signature below indicates that I agree to the above. I also grant Woodstock Physical Therapy to contact me at the following phone number(s) and to leave a message on my voice mail.

________________________	________________________	________________________
Home Phone	Work/Alt. Phone	Cell Phone

______________________________	______________________________
Patient Signature	Date

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