INITIAL HEALTH STATUS

Patient Name ____

Describe Your Current Problem and How It Began ____
____
____

Onset date/Surgery date____

Is this? ___ Work Related ___ Auto Related ___ N/A

How often are your symptoms present?

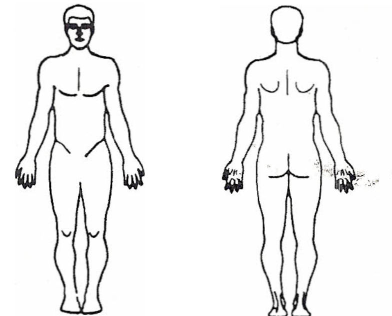
___ Constantly (76-100% of the day) ___ Occasionally (26-50% of the day)

___ Frequently (51-75% of the day) ___ Intermittently (0-25% of the day)

Describe the nature of your pain:

___ Sharp ___ Dull Ache ___ Numb ___ Shooting ___ Burning ___ Tingling

Indicate below where you have pain or other symptoms



How is your condition changing?

___ Getting Better ___ Not Changing ___ Getting Worse

Current complaint (how you feel today);

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, your household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Have you had X-rays, MRI, CT Scan for your area(s) of complaint? ___ Yes ___ No (if yes, circle which one)

Date(s) taken____________________What areas were taken?____________________

Please check all of the following that apply to you;

___ Recent Fever
___ Diabetes
___ High Blood Pressure
___ Cardiac Condition
___ Stroke (date) ____________________
___ Dizziness/Fainting
___ Cancer/Tumor (explain) ____________________
___ Asthma____________________
___ Osteoporosis
___ Other Health Problems (explain) ____________________
____

___ Numbness (location) ____________
___ Urinary Problems
___ Currently Pregnant, # weeks____
___ Abnormal Weight ___ Gain ___ Loss
___ Pain Unrelieved by Position or Rest
___ Pain at Night
___ Surgeries ____________________
____
____
___ Current Medical Conditions ____________________
____

Who have you seen for your condition before today?

___ No One ___ Medical Doctor ___ Massage Therapist ___ Other
___ Chiropractor ___ Physical Therapist ___ Acupuncturist

What treatment did you receive and when?____

What is your occupation?____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or If I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I give authorization to this provider/practitioner to contact my physician, if necessary.

Peak Physical Therapy of Brooklyn, PLLC
3131 Kings Highway
Suite A5
Brooklyn, NY 11234

I authorize payment to be made directly to Peak Physical Therapy of Brooklyn, PLLC. In the event payment is not forthcoming by insurance company, or that a portion of payment is withheld due to deductions of co-insurance, co-payments, or unmet deductibles, I will be responsible for the charges incurred.

____ _______________________

Patient's Signature Date

ATTENTION: If you re receiving therapy without a referral ONLY:

Please be advised that your treatment may not be covered by your health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner, Treatment may be a covered expense if provided with a referral.

Date treatment is to begin____

Name____

Address____

Signature______________________________Date_________________________

Treating Physical Therapist____

Treating Physical Therapist's signature______________________________________

_____Peak Physical Therapy of Brooklyn, PLLC_____

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Peak Physical Therapy of Brooklyn, PLLC's Notice of Information Practices. I understand that Peak Physical Therapy of Brooklyn, PLLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any other administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that that Peak Physical Therapy of Brooklyn, PLLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Peak Physical Therapy of Brooklyn, PLLC's, Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____
Patient Name (Print)

____
Signature

____

Peak Physical Therapy of Brooklyn, PLLC
3131 Kings Highway
Suite A5
Brooklyn, NY 11234

I authorize payment by my insurance carrier to be made payable to PEAK PHYSICAL THERAPY OF BROOLYN, PLLC.

In the event my insurance carrier does not make payment, or a portion of payment is withheld due to deductions such as; co-insurance, co-payments, unmet deductibles, etc., I will be personally responsible to pay PEAK PHYSICAL THERAPY OF BROOKLYN, PLLC for the charges incurred. I also acknowledge that if it is necessary to refer this matter to a collection agency, I agree to all reasonable collection fees.

Patient's signature___________________________________ Date______________________________

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DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees

Name:____ Relationship:_________________________

Name:____ Relationship:_________________________

Name:____ Relationship:_________________________

Name:____ Relationship:_________________________

____
Patient’s Name

____
Patient’s Signature

____
Date