Dear Patient,

Thank you for choosing Active Physical Therapy Solutions for your treatment needs! In an effort to serve you best, we ask that you thoroughly complete the following paperwork. This new patient paperwork serves as a tool to make your initial evaluation as well as your follow up visits with us as efficient and effective as possible. At Active Physical Therapy Solutions, we are devoted to helping you get the answers you need and in order to do so we need as much information about you as possible. We also ask that you please **arrive 20 minutes early** for your initial evaluation so that your therapist can review the paperwork before your scheduled appointment time. Thank you and we look forward to being your ***active solution to achieving your personal goals!***

Sincerely,
Active P.T. Solutions Staff

ACTIVE PHYSICAL THERAPY SOLUTIONS PC
91 Columbus St. Auburn, NY 13021 (315) 515-3117 F: (315) 515-3121
Office Hours: Mon 8:30am-5:30pm, Tues 8:30am-7:00pm, Wed 8:30am-5:30pm, Thurs 8:30am-5:30pm, Fri 8:30am-4:00pm

***In an effort to keep the office running as efficiently as possible, this paperwork needs to be completely filled out when you arrive for your appointment. If it's not complete, your appointment will be rescheduled. We also ask that you arrive 20 minutes early so we can review your paperwork before your appointment. Thank you for your co-operation!**

Patient Information

Date Completed: ______________________

Name ____ Nickname ____

Sex __________ DOB __________________________ Age __________

Address ____ City, State, Zip ____

Home Phone ___________________________ Cell Phone ___________________________ Work Phone __________________________

Employer ____ Occupation ____

Employer Address ____ City, State, Zip ____

Current work status ____Working: ____Full- time ____Part-time ____Full- duty ____Light-duty ____Not working____________________

Retired __________________ Date of Retirement __________________ Former Occupation ________________________________

Email Address: ____

Marital Status ____Married ____Single ____Separated ____Divorced ____Widowed ____Other ________________________________

Primary Insurance Information

Name and Address of Insurance Company ____

Name of Insured ____ Relationship to Patient __________________________

Employer ____ DOB of insured _________________________________

Policy # ____

Secondary Insurance Information

Name and Address of Insurance Company ____

Name of Insured ____ Relationship to Patient __________________________

Employer ____ DOB of insured _________________________________

Policy # ____

Primary Doctor Information

Primary Doctor Name ____ Phone # ____________________________________

Doctor's Address ____

Date of last visit ____

Review of Systems Family - Personal - Medical Histories

Patient Name: ____ Date: ____________________

Please mark any condition or symptoms you have had in the past or are currently experiencing.

Family History	Your General History	Endocrine System	Eye/Ear/Nose/Throat
___ Diabetes ___ Thyroid disease ___ Tuberculosis ___ Kidney disease ___ High blood pressure ___ Heart disease / stroke ___ Musculoskeletal disease ___ Cancer ___ Other	___ Trauma/Injuries ___ Height Change ___ Fever/Chills ___ Sweats ___ Malaise/fatigue ___ Weakness ___ Cancer	___ Heat / Cold intolerance ___ Thyroid problems ___ Hypo ___ Hyper ___ Diabetes ___ Type I (Juvenile) ___ Type II (Adult) ___ Neck surgery / irradiation ___ Adrenal Fatigue	___ Visual problems ___ Eye irritations ___ Pain in the eyes ___ Other eye problems ___ Difficulty hearing / deaf ___ Ringing in ears / dizziness ___ Ear growth / discharge ___ Ear pain ___ Vertigo

Eye/Ear/Nose/Throat (cont)	Cardiovascular System	Cardiovascular System (cont)	Gastrointestinal System
___ Nose bleeds ___ Change in ability to smell ___ Sneezing ___Nose growths / discharge ___ Nose pain ___ Sinusitis	___ Shortness of breath ___ Chest discomfort / pain ___ Sudden calf pain/while walking	___ High blood pressure ___ Past heart disease ___ Rheumatic fever ___ Pacemaker ___ Anemia ___ Bruise Easily	___ Change in appetite ___Food intolerance ___ Nausea / Vomiting ___ Vomiting of blood ___ Peptic Ulcer ___ Indigestion / Heartburn ___ Abdominal pain ___ Abdominal swelling ___ Gas ___ Change in stool/color/etc.

Gastrointestinal System (cont)	Urinary System	Urinary System (cont)	Respiratory System (cont)
___ Constipation ___ Diarrhea ___ Hernia ___ Hemorrhoids ___ Gallbladder disease ___ Pancreatitis ___ Alcohol intake ___ Type _______________ ___ Amount______________ ___ GERD ___ IBS ___ Crohn's Disease ___ Celiac Disease	___ Frequent urination ___ Day/ _________ night ___ Daily fluid intake ______ ___ Pain on urination ___ Change in urine color / etc ___ Difficulty in starting stream ___ Difficulty in holding urine ___ Discharge ___ Flank pain	___ Urinary tract infections ___ Kidney disease ___ Pelvic pain ___ Other problems **Respiratory System** ___ Difficulty in breathing ___ Cough ___ Blood in sputum ___ Wheezing/asthma	___ Tuberculosis / exposure ___ Pneumonia / lung infections ___ Cigarette smoking history Daily # ______, yrs ___ ___ Other tobacco use Cigar ______ Pipe ____ Chewing tobacco ______ Amount ______ yrs_____ Environmental exposure Type _______________ Amount _____________ ___ Seasonal Allergies

Please mark any condition or symptoms you have had in the past or are currently experiencing.

Neurological System	Musculoskeletal	Breast	Diet / Vitamins
___ Headaches ___ Epileptic seizures ___ Tics / spasm ___ Dizziness / fainting ___ Disturbances of sensation ___ Unusual weakness ___ Head trauma ___ Stroke ___ History of Concussion ___ Other problems	___ Joint stiffness / decreased motion ___ Joint pain ___ Joint swelling ___ Muscle cramps ___ Muscle weakness ___ Muscle wasting ___ Neck pain ___ Mid back pain ___ Low back pain	___ Bumps / lumps / mass ___ Pain / tenderness ___ Dimples in breast ___Change in color, size or shape ___ Nipple discharge ___ Other breast problems ___ Breast implants	___ Vegetarian ___ Take Supplements _______________ **Implants** ___ Cardiac pacemaker ___ Penile / other _______

Skin / Hair / Nails	Musculoskeletal	Reproductive System	Female Patients
___ Change in skin texture ___ Change in skin temp ___ Skin dryness / wetness ___ Unusual skin coloration ___ Rashes / itching / sores ___ Skin growths	___ Sacroiliac pain ___ Tailbone pain ___ Arm problem ___ Leg pain ___ Fracture / dislocations ___ Sprain / strains ___ Other injuries or problems	___ Genital lesions / sores ___Genital mass / growth / pain ___ Syphilis ___ HIV positive ___ Gonorrhea ___ Change in sex drive ___ Birth control method Type_______________ How long? _________	___ 1st period Age ______ Yr ______ ___ Light flow ___ Moderate flow ___ Heavy flow ___ Pain 0 1 2 3 4 5 ___ First day of last cycle ________________ Date of last pap ______

Skin / Hair / Nails	Psychological History	Diet / Vitamins	Female Patients Menopause
___ Mole growths ___ Skin cancer ___ Skin pain ___ Change in hair texture / condition ___ Change in hair growth / loss ___ Change in shape of finger / toenails ___ Change in nail color ___ Other problems ___ Lipoma	___ Anxiety ___ Depression ___ Hospitalization ___ Therapy ___ Bipolar Disorder **Hospitalization / Meds** ___ Other hospitalizations not listed above ___ Current use of any drugs, prescription or recreational	___ Do you skip breakfast? ___ Eat junk food ___ On a special diet ___ Gluten Free ___ Dairy Free ___ Non GMO ___ Probiotics	___ Post menopause bleeding ___ Abdominal pain ___ Premenstrual fluid retention ___ # of pregnancies ___ # of children ___Difficult delivery ___ PMS syndrome ___ Hysterectomy Date ____________

Patient Signature ____ Date ______________________

Patient Health Questionnaire

1. Personal information: Estimated Height: _________ Weight: ________

2. Describe your present symptom(s)

   ____

3. How did your symptom(s) start?
   1. Gradual onset, no particular injury
   2. Work injury
   3. Motor Vehicle accident: ☐Car/Truck ☐ Motorcycle ☐ ATV ☐Boat/Jet Ski ☐ Snowmobile
   4. Sports Injury: Throwing, Swimming, Running, Golf, Tennis, Other ______________________________

4. **When did your symptom(s) start?** (day/month/year) ____________________________________

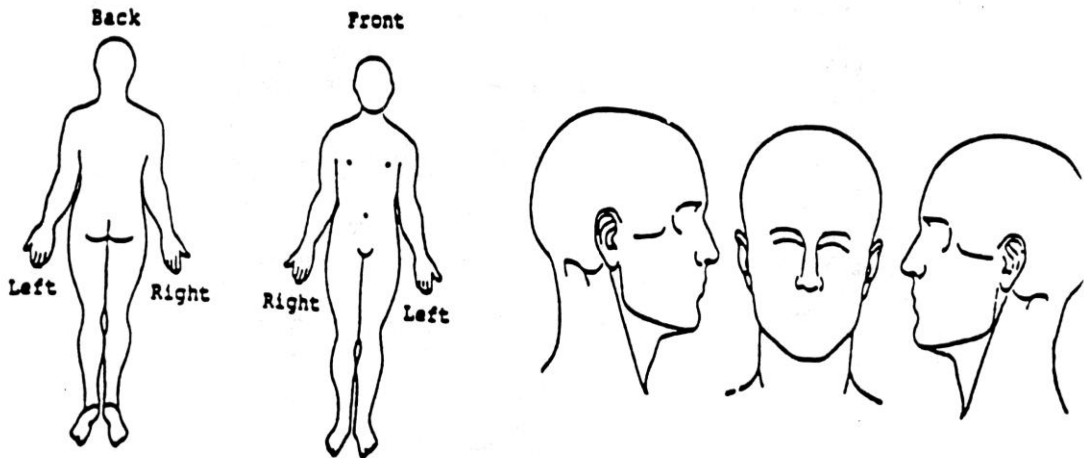
   (If Work Comp or No Fault, Date of Injury or accident is required)

5. Have you ever had Physical Therapy or Chiro for these symptoms? ☐ Yes ☐ No Initials of Patient __________

   If so, where did you go and how long did you attend? ____

6. On the following diagrams indicate the location of your complaints, using the symbol key.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^^	======	ooooooooo	....	///////	xxxxxxx



7. Indicate each symptom's intensity by making a slash along the corresponding line from no pain (left) to worst possible pain (right).

   No Pain (0)←--→ (10) Worst Pain

8. Indicate which of the following activities make your symptom (s) better (B) or worse (W).

B W Sitting	B W Bending forward	B W Movement / activity	B W Laying down
B W Standing	B W Bending backward	B W Inactivity	B W Sleep
B W Computer	B W Reaching Overhead	B W Driving	B W Exercise

9. Patient Functional Goals: List (3) Goals you would like to achieve from your treatment

   1. ____
   2. ____
   3. ____

10. Have you fallen 2 or more times in the last 12 months without injury Yes _________ No _________

    Have you fallen 1 time in the last 12 months with injury? Yes_________ No _________

11. List **ALL** medications **and** vitamin supplements you are currently taking:

Name	Type	Amount taken per day	Condition taken for

Types of medications (Rx – prescription OTC – over the counter)

1. Antidepressant – Rx
2. Anti-inflammatory – Rx
3. Muscle relaxant – Rx
4. Narcotic / codeine - Rx
5. Acetaminophen, aspirin, ibuprofen - OTC
6. Other – describe above

12. If you have ever had **ANY** surgical procedures, please list to the best of your ability below:

☐ If you are denying ever having a previous surgical procedure, please check box and initial. ___________

Name of Procedure	Date performed	Condition performed for

13. Legal and insurance information:

Is this a work related injury? 1. No 2. Yes Initials of Patient __________

Did this injury happen at school? 1. No 2. Yes Initials of Patient __________

Will APTS be billing the school's insurance? 1. No 2. Yes Initials of Patient __________

Did this injury occur in a Motor Vehicle Accident? 1. No 2. Yes Initials of Patient __________

If this injury occurred in an MVA or at work and we are not billing WC or MVA please explain.

____

Are you currently or, do you anticipate being involved in any litigation relating to your symptom(s)?

1. No 2. Yes

14. Who filled out this questionnaire?
1. Patient without help from others
2. Patient with help from family/friends
3. Family member or friend of patient
4. Health care provider during the history
5. Other

12. What made you decide to choose Active Physical Therapy Solutions for your Physical Therapy and/or Chiropractic needs?

Please check the appropriate box and explain.

☐ Active P.T. Solutions Employee ____________________ ☐ Physician____________________

☐ Patient ____________________ ☐ Friend/Relative ____________________

☐ Newspaper Ad/Article ____________________ ☐ Billboard/Signage ____________________

☐ Website ____________________ ☐ Other ____________________

Policies & Procedures

Authorization for Medical Information Release

I authorize Active Physical Therapy Solutions PC to furnish my insurance company with medical information they may request regarding my condition or treatment. I authorize my referring health care provider to release any diagnostic reports and/or surgery reports to Active Physical Therapy Solutions PC. Furthermore, I authorize Active Physical Therapy Solutions PC to release any treatment reports to the referring physician as it corresponds with the physical therapy prescription.

Authorization of Treatment

I hereby authorize treatment of the below-named patient by Active Physical Therapy Solutions PC.

I understand that any patients under the age of 18 **must be accompanied to the initial physical therapy or chiropractic evaluation by the parent or legal guardian of the patient.** Failure to comply may result in rescheduling your appointment.

Privacy Notice & Patient Bill of Rights

I have read and understand Active Physical Therapy Solutions PC Notice of Privacy Practices and Patient Bill of Rights.

I certify that I am 18 years of age and/or the legal guardian/guarantor of the patient named below.

Designated person(s) to aid in patient care or to communicate medical information in the case of an emergency:

Name: ____________________ Relationship: ____________________

Phone #: ____________________

Name: ____________________ Relationship: ____________________

Phone #: ____________________

Printed Name of Patient ____________________**Date**____________________

Signature of Patient and/or Legal Guardian____________________

Financial Agreement

Please write your initials after **EVERY** statement.

I am responsible for making sure that Active Physical Therapy Solutions PC has accurate insurance information for each date of service at the time services are rendered. If I fail to comply, I am responsible for all denied services. _______

If my insurance policy allows a certain number of visits for physical therapy or chiropractic services, I am responsible for tracking those visits as well as payment for any treatment given past that allowance. _______

I agree to be fully responsible for any services deemed as non-covered or denied by my insurance company for contractual reasons for each episode of care at Active PT Solutions. _______

I recognize and accept complete financial responsibility for any balance remaining after the payment of correct benefits by an insurance company. _______

I understand that I'm responsible for verifying that Active Physical Therapy Solutions PC is in-network with my insurance. Active Physical Therapy Solutions PC will bill **out-of-network** but, I understand that I am responsible for the remaining balance after Active Physical Therapy Solutions PC accepts the out of network payment by my insurance company and I agree to pay for any denied or unpaid services rendered by Active Physical Therapy Solutions PC. _______

If I am **uninsured**, or become uninsured during the course of treatment, I understand that I am responsible for payment in full at the time of service, unless prior arrangements have been made with the Associate Director of the office. _______

I assign insurance benefits for all services rendered by permitting payment directly to Active Physical Therapy Solutions PC, for services rendered. _______

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below.

Printed Name of Patient ____ **Date**______________________

Signature of Patient and/or Legal Guardian____

Cancellation Policy

The success of your treatment is important to us. In order to have a successful treatment plan your attendance is imperative. In an effort to accommodate the treatment schedule for all patients, we request that you call at least 24 hours prior to your appointment to cancel or reschedule**. If you cancel or no show two or more consecutive appointments, your future appointments will be cancelled without notice** and a $25 fee will be assessed in order to reschedule an appointment. Active Physical Therapy Solutions reserves the right to waive such fees as a courtesy in the event of severe weather, health emergencies and special circumstances. **This fee is not reimbursable by your insurance carrier and is due before you will be treated again.**

Please feel free to discuss any questions or concerns with the Associate Director of Active Physical Therapy Solutions PC and thank you for your cooperation on this very important matter!

I have read, understand and agree to the Active Physical Therapy Solutions PC cancellation Policy. It has been explained to me and my questions have been answered to my satisfaction.

Printed Name of Patient ____ **Date** ____________________

Signature of Patient and/or Legal Guardian ____