# ACTIVE PHYSICAL THERAPY SOLUTIONS PC

91 Columbus Street, Auburn, NY 13021 T: (315) 515-3117 F: (315) 515-3121

**Patient Information Update Form** **Date Completed:** ____________________

Name ________________________________________ Nickname ______________________

Sex ________ DOB __________________ Age ________ SS# ________________________

Address ______________________________City, State, Zip_________________________

Home Phone ________________ Cell Phone ________________Work Phone _______________

Employer ______________________________________ Occupation ____________________

Employer Address ____________________________ City, State, Zip ___________________

Retired ____________ Date of Retirement ____________ Former Occupation ______________

Marital Status ___Married, ___Single, ___Separated, ___Divorced, ___Widowed, ___Other, ______________

Email Address: ____________________________________________________________

## Primary Insurance Information

Name and Address of Insurance Company _____________________________________________

Name of Insured ___________________________________ Relationship to Patient ______________

Employer ______________________________________ SS# ________________________

Policy # ___________________________________ DOB of insured ______________________

## Secondary Insurance Information

Name and Address of Insurance Company _____________________________________________

Name of Insured ___________________________________ Relationship to Patient ______________

Employer ______________________________________ SS# ________________________

Policy # ___________________________________ DOB of insured ______________________

Primary Doctor Name _______________________________ Phone # _____________________

Doctor's Address___________________________________________________________

Date of last visit___________________________________

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

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

**Did this injury occur at school?** 1. No 2. Yes Initials of Patient _________

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

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

1. No 2. Yes

Indicate the type of disability benefits you are receiving, or applying for, if any:

1. Workers compensation
2. Auto insurance
3. Long term disability
4. Social security
5. General assistance
6. None
7. Other

**Patient Health Questionnaire**

1. Personal Information: Estimated Height: ____________ Estimated Weight:____________
2. Describe your present symptom (s)

_______________________________________________________________________________

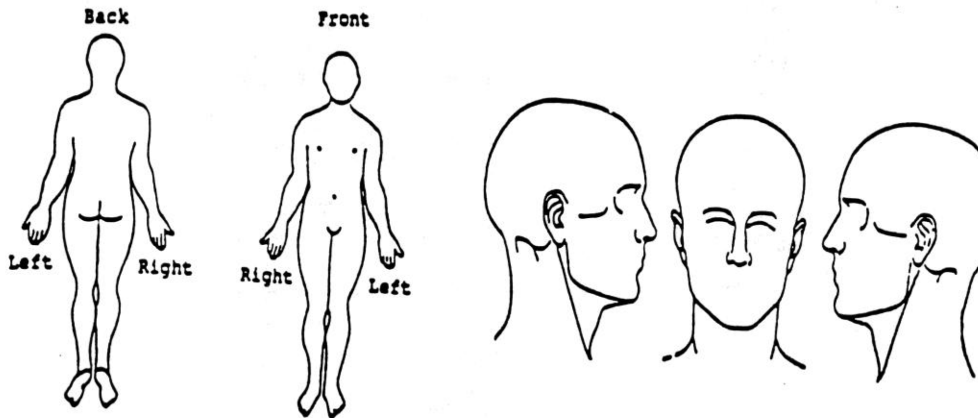
3. Describe how and when your present symptom (s) started.

How did your symptom (s) start?
1. Gradual onset, no particular injury
2. Work injury
3. Motor Vehicle accident
4. Sports Injury: Throwing, Swimming, Running, Golf, Tennis, Other ______________________________
5. Other

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

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

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




6. 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**

7. 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 |

8. Patient Functional Goals: List (3) Goals you would like to achieve from your treatment
1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________

9. 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 _________