CARPENTER
Physical Therapy

MEDICAL AND SOCIAL HISTORY

Date: _____

Name: (First)_____ **(Last)**_____ **(MI)**_____ **Sex:** ☐ **M** ☐ **F**

Date of Birth: _____/_____/_____ **Age:** _____ **Are you:** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Occupation/Training: _____ ☐ **Full Time** ☐ **Part Time** ☐ **Retired** ☐ **Student**

Do you live alone or with someone? ☐ **YES** ☐ **NO. If, yes please provide their name and relationship:**

Name:_____ **Relationship:** _____

Email address:_____

We want to stay connected with you and keep you informed of current events and promotions. Would you like to stay connected with us through our Carpenter Physical Therapy Mighty Networks online community? ☐ **YES** ☐ **NO**

Emergency Contact: (Print Name)_____ **Phone #:**_____

Relationship:_____

Please list any major life changes you've experienced during **the past year**. (ex. Job change, death of a family member, etc.)

_____

_____

Please list any **major traumas*** you've experienced during the course of your life and any residual effects. (These "residual effects" may be physical, psychological, emotional, or spiritual.)_____

_____

_____

** "Trauma is not what happens to you; trauma is what happens inside you as a result of what happens to you." Dr. Gabor Maté*

During the past month, have you often been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

Is this something with which you would like help? ☐ Yes ☐ Yes, but not today ☐ No

Which apply to your situation?	**YES**	**NO**
☐ Work related injury	☐	☐
Date of Injury: _____		
Are you currently working? ☐ Yes ☐ No	☐	☐ Have you had therapy in the past 12 months?
☐ Motor vehicle accident	☐	☐ Do you participate in regular exercise/sporting activities?
Date of accident:_____	☐	☐ Have you had any other treatment or tests for **this event?**
☐ Recurrence of previous injury		Tests or treatments received:
☐ Injury related to lifting		_____
☐ Athletic/recreational injury		_____
☐ Injury related to falling		_____
☐ Cause unknown		

What do you do for self-care? _____

_____

How do you like to spend your free time? (Example: Hobbies, activities, etc.)_____

_____

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MEDICAL HISTORY:

Please check if you have had **OR** do have any of the following:

- ☐ Allergies
  Type:_____
- ☐ Blood clot(s)
- ☐ Blood disorder
- ☐ Broken bones/fracture
- ☐ Cancer:
  Where: _____
  When:_____
- ☐ Circulation/Vascular problems
- ☐ Chest Pain/Discomfort
- ☐ Concussion
  When:_____
- ☐ Depression
- ☐ Anxiety
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Recent dizziness
- ☐ Reproductive problems

- ☐ Headaches
- ☐ Head injury
- ☐ Heart problems:
  _____
- ☐ High blood pressure
- ☐ Current hot Flashes
- ☐ Infectious disease
  (TB, Hepatitis, Lyme etc.)
- ☐ Joint or Bone Infection
- ☐ Stomach/Intestinal problems:
  _____
- ☐ Fibromyalgia
- ☐ Kidney problems
- ☐ Low blood pressure
- ☐ Hypoglycemia
- ☐ Lung problems:
  _____
- ☐ Night Sweats
- ☐ Osteoarthritis
  Where:_____
- ☐ Osteopenia/Osteoporosis
- ☐ Other Autoimmune Disease(s)
  _____
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Repeated infections
- ☐ Rheumatoid Arthritis
- ☐ Seizures/Epilepsy
- ☐ Skin disease
- ☐ Prostate disease/cancer
- ☐ Stroke
- ☐ Thyroid problems:
  _____
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Urinary Urgency/ Dysfunction
- ☐ Other:

Have you had major surgery within the past 3-5 years: ☐ Yes ☐ No If Yes, when:_____

Briefly explain:_____

_____

Have you had any non-motorized vehicle accidents in the past 3-5 years: ☐ Yes ☐ No If yes: Date:_____

Briefly explain:_____

_____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Name: _____ Specialty: _____ Phone #:_____

Name: _____ Specialty: _____ Phone #:_____

Name: _____ Specialty: _____ Phone #:_____

Name: _____ Specialty: _____ Phone #:_____

Name: _____ Specialty: _____ Phone #:_____

PROVIDER LIST WAS REVIEWED WITH PATIENT AND IS CURRENT AS OF:

DATE REVIEWED: _____ **PROVIDERS INITIALS:**_____

DATE REVIEWED:_____ **PROVIDERS INITIALS:** _____

DATE REVIEWED:_____ **PROVIDERS INITIALS:** _____

DATE REVIEWED:_____ **PROVIDERS INITIALS:** _____

PLEASE NOTE ANY CHANGES OR ADDITIONS TO YOUR PROVIDER LIST IN THE SPACE BELOW YOUR LIST OF MEDICATIONS.

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Please list all prescribed and over-the-counter medications you take:

MEDICATION LIST

MEDICATION/SUPPLEMENT/VITAMIN	DOSAGE	ROUTE	FREQUENCY
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:
		☐Oral ☐Patch ☐Inhaler ☐Injection	☐ 1x/day ☐ 2x/day ☐ 3x/day
		Other:	Other:

I ATTEST THAT MY MEDICATION LIST IS CURRENT AS OF THE FOLLOWING DATE:

PATIENTS NAME: ______________________________ **INITIALS:**______________ **DATE:** ____________

PATIENTS NAME: ______________________________ **INITIALS:**______________ **DATE:** ____________

PATIENTS NAME: ______________________________ **INITIALS:**______________ **DATE:** ____________

PATIENTS NAME: ______________________________ **INITIALS:**______________ **DATE:** ____________

PATIENTS NAME: ______________________________ **INITIALS:**______________ **DATE:** ____________

NEW PROVIDERS OR PENDING REFERRALS:

Please list ALL PENDING REFERRALS OR NEW physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...) | **DATE OF 1ST ENCOUNTER**

Name: ____________________ Specialty: ____________________ Phone #:________________ | ________________

Name: ____________________ Specialty: ____________________ Phone #:________________ | ________________

Name: ____________________ Specialty: ____________________ Phone #:________________ | ________________

Name: ____________________ Specialty: ____________________ Phone #:________________ | ________________

Name: ____________________ Specialty: ____________________ Phone #:________________ | ________________

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CURRENT ISSUE:

Present symptoms _____ Present Since: _____

How did it start? ☐ Gradual ☐ sudden ☐ Injury Is it? ☐ Improving ☐ unchanging ☐ worsening

Did you have an X-ray, MRI, or other imaging study? ☐ Yes ☐ No If yes: Date:_____ What type of study and what part(s) of your body?_____

Constant symptoms: _____Intermittent symptoms:_____

Previous Episodes? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11+ Previous Treatments/Response to treatments:_____

_____

Worse with? ☐ Bending ☐ sitting ☐ lying ☐ turning/twisting Other:_____

Better with? ☐ Bending ☐ sitting ☐ lying ☐ turning/twisting Other:_____

Worse? ☐ in AM ☐ as the day progresses ☐ in PM Better? ☐ in AM ☐ as the day progresses ☐ in PM

Do you feel better when you are: ☐ Still ☐ On the Move?

Sleeping Postures: ☐ belly ☐ back side: ☐ R ☐ L Disturbed Sleep? ☐ Yes ☐ No

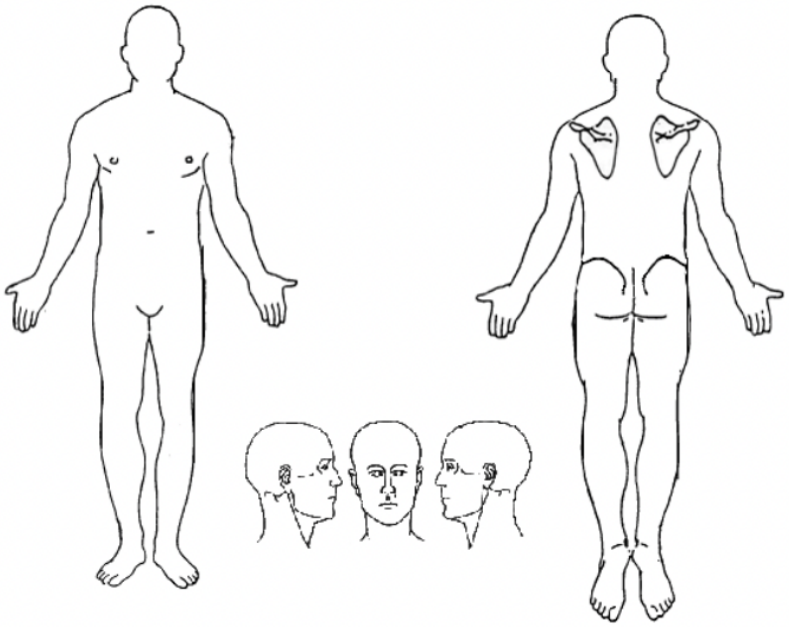
Do you have pain with: ☐ coughing ☐ sneezing ☐ straining?

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:
1.
2.
3.

On the scales below, please indicate the number which best represents the severity of your pain is.

***Average* for the last 48 hours:**	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Pain**
***Best* for the last 48 hours:**	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Pain**
***Worst* for the last 48 hours:**	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Pain**

Please indicate on the diagram below any areas of pain and/or scars.



CONSENT:

I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

Print Name: _____

(Sign) _____

Date: ____/___/_____

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PATIENT NAME: _____ **EMAIL ADDRESS:**_____

(If you would like to join our Mighty Networks Community.)

ADDRESS:_____

CONSENT TO PHYSICAL THERAPY EVALUATION & TREATMENT AT CARPENTER PHYSICAL THERAPY PRACTICE:

I hereby request and authorize medical treatment recommended by my referring physician or by self-referral. The undersigned consents to treatment of Physical Therapy under the general and special instructions of the referring physician or under the New York State Direct Access Law. Signatures validates patient has read this notice in entirety.

NOTICE OF ADVICE FOR SELF-REFERRED PATIENTS:

I have been informed of the possibility that physical therapy treatment may not be covered by my health care insurer without the referral of a physician, dentist, podiatrist, or nurse practitioner, but may be a covered expense, if treatment was rendered pursuant to such referral. Per NY State Physical Therapy Practice Act treatment is allowed for 30 days or 10 visits (whichever occurs first). A referral is required for treatment beyond that point.

Treatment will begin on: _____

Therapist Name: _____ License # _____

Therapist Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and PAYMENT OF BENEFITS:

I hereby authorize **CARPENTER PHYSIAL THERAPY, PLLC** to disclose all or any parts of my medical record requested by the insurance company, it's designated agent, or liable third parties to include Medicare, worker's compensation carrier, employer, case manager, and attorney whose benefits have been assigned for purposes of benefit payment. **I hereby authorize payment** directly to Carpenter Physical Therapy, PLLC of all insurance benefits otherwise payable to me for services rendered. **I have been provided** with a copy of Carpenter Physical Therapy's Privacy Policy and understand how they will handle my protected health information.

I further authorize the transfer of copies of my medical records to the referring physician, the patient and any health care facility or physician, which I transfer. I also give Carpenter Physical Therapy, PLLC **permission to obtain** any medical or billing records from an insurance carrier, legal office, or other medical facility.

ADDITIONAL CHARGES:

An addition charge of **$50.00** ***(administrative fee)*** **AND** **$100.00** ***(clinical documentation fee)*** will be applied should the patient intend to submit proof of payment for services rendered to their health insurance company for reimbursement. **It is the patient's responsibility to notify the office of their intent** ***prior to scheduling any appointment(s).***

Requesting assistance or for updated documentation for your insurance company after your session(s) has/have occurred will not be honored.

By signing and dating below, I am confirming I have been informed of the additional charges related to insurance reimbursement assistance. By checking one of the boxes below, I am informing **Carpenter Physical Therapy, PLLC.** of my intent regarding submitting proof of payment for services rendered to my insurance company and agree to the additional charges, should I elect to do so.

I intend to submit my proof of payment to my insurance company for reimbursement: ☐ **YES** ☐ **NO**

I agree to the additional charges: ☐ **YES** ☐ **NO** ☐ **I will not be submitting proof of payment to my insurance for reimbursement**

Name:_____ **Signature:**_____ **Date:**_____

CANCELATION POLICY

Our patients are very important, and our appointment times are limited, therefore if you are unable to keep your scheduled appointment, please contact our office as soon as possible, as we may be able to fill your appointment time with a patient on our waiting list. If you fail to notify our office of your inability to keep your scheduled appointment and do not show at your scheduled time**, you will be charged a $40 fee**. If you do not show for >1 of your scheduled appointments, all of your future appointments will be cancelled, and you will need to contact our office to re-schedule.

_____ _____ _____

Signature of Patient or Authorized Representative **Signature of Witness** **Date**