Oakdale Physical Therapy
& Sports Rehabilitation

1092 West Jericho Tpke., Commack, NY 11725
Tel: (631) 366-3025 | Fax: (631) 366-3026

4544 Sunrise Highway, Oakdale, NY 11769
Tel: (631) 218-0042 | Fax: (631) 218-3606

PATIENT HEALTH QUESTIONNAIRE

Name:_____ Date:_____

1. Please check off who referred you to our office.
MD Office Staff MD Insurance Listing Friend/Family Telephone Book

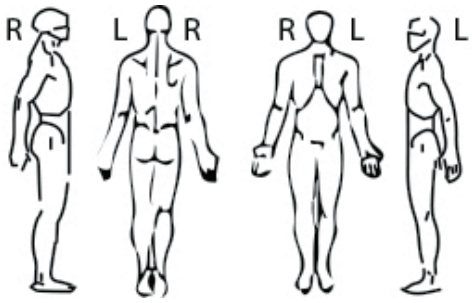
2. Please describe your current complaint or limitation._____

_____

3. What is your goal for therapy?_____

2a. Please describe the nature of your pain:

Sharp Pain	Constant (76-100%)
Dull Pain/Ache	Frequent (51-75%)
Throbbing	Occasional (26-50%)
Numbness	Intermittent (25% or less)
Shooting	
Burning	Please mark where you have
Tingling	pain or other symptoms ➡



4b. Indicate the intensity of your pain at rest: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain
Indicate the intensity of your pain with movement : No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

4c. What movement causes your pain to increase?_____

2d. Since this condition began, your symptoms have: decreased not changed increased

2e. Your symptoms are worse in the:
morning afternoon night increase during the day same all day

4. When did your problem begin? days ago months ago years ago Date if possible:
4a. Describe how your problem began:_____

5. Did you have surgery? Yes No Date of surgery if possible:

6. In the past, were you treated for this same problem? Yes No
6a. When and what treatment did you receive?
6b. If yes, who did you see for this condition?
MD Physical Therapist Occup. Therapist Chiropractor Other:

7. What makes your problem better?
Nothing Lying Down Standing Sitting Movement/Exercise Inactivity

8. What makes your problem worse?
Nothing Lying Down Standing Sitting Movement/Exercise Inactivity

9. What is your occupation? P/T F/T
9b. Work status changed due to your condition? Yes No
9c. What is your current work status?

F/T, no restrictions	P/T, no restrictions	Unemployed
F/T, with restrictions	P/T, with restrictions	Retired
F/T, homemaker	F/T or P/T student (circle one)	Off work due to restrictions

PAST	PRESENT		PAST	PRESENT	
_____	_____	High Blood Pressure (401.9)	_____	_____	Systemic Lupus (710.0)
_____	_____	Angina (413.9)	_____	_____	Hepatitis (573.3)
_____	_____	Heart Attack (410.9)	_____	_____	Epilepsy (349.5)
_____	_____	Stroke (436)	_____	_____	Diabetes (250.0)
_____	_____	Asthma (493.9)	_____	_____	Rheumatoid Arthritis (714.0)
_____	_____	HIV/AIDS (042)	_____	_____	Pregnancy
_____	_____	Cancer (199.1) Location: _____ Date: _____	_____	_____	Other:_____
_____	_____	Tumor (229.9)	_____	_____	Drug or Alcohol Dependence (303.9)

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MEDICATION LIST

Patient Name:_____

D.O.B.:_____

Date:_____

MEDICATION	DOSAGE	X DAILY

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Notice of Privacy Practices Acknowledgment

By my signature below, I hereby acknowledge receipt of this Notice of Privacy Practices, and I acknowledge that Beach & Foster Physical Therapy, P.C. will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting health care operations.

I understand that I may request in writing that Beach & Foster Physical Therapy, P.C. restricts how my private information is used or disclosed. I also understand that in providing treatment, submitting billing, and conducting healthcare operations, Beach & Foster Physical Therapy, P.C. has my permission to disclose my protected health information to the following:

_____ Primary Care / Family Doctor

_____ _____ (relationship to me)

_____ _____ (relationship to me)

_____ _____ (relationship to me)

_____ _____

Print Patient's Name

Signature of Patient or Parent / Guardian

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Patient Authorization and Guarantee

RELEASE OF INFORMATION
I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Oakdale Physical Therapy & Sports Rehabilitation to my physician(s), as well as any organization responsible for payment of my account, and any legal representative invoiced in my litigation. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

ASSIGNMENT OF INSURANCE BENEFITS
I hereby authorize that the payment of authorized benefits be made directly to Oakdale Physical Therapy & Sports Rehabilitation for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

CONSENT OF TREATMENT
I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of Oakdale Physical Therapy & Sports Rehabilitation.

GUARANTEE OF ACCOUNT
In consideration of services rendered to me by Oakdale Physical Therapy & Sports Rehabilitation, I hereby guarantee payment for any and all services rendered to me in which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance and/or deductible, which I am fully responsible for paying. Although Oakdale Physical Therapy & Sports Rehabilitation will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will immediately notify Oakdale Physical Therapy & Sports Rehabilitation of any changes in my insurance coverage while receiving physical therapy.

MEDICARE
I hereby certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release this to the Social Security Administration or its intermediates or carriers any such information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

HIPAA PRIVACY
I hereby certify that I read and understand the HIPAA privacy statement. I acknowledge I was given an opportunity to receive a copy of the privacy statement at this time or any time in the future.

I, _____ by signing this document, acknowledge my consent to the above.

Signature: _____ Date:_____