HEALING TOUCH PHYSICAL THERAPY AND REHABILITATION P.C.

First Name: _____ Date of injury/onset: _____ Today's Date: _____

Last Name: _____ Date of Birth: _____ Age: _____

Social Security: _____-_____-_____ Sex: M F Marital Status: S M D W

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Cell Phone: ( ) _____-_____ Email: _____

Injury Area: _____ Accident Related? Yes No If yes, Auto Work

Who should we thank for this referral: _____

Referring Physician: _____ Phone: ( ) _____-_____

Primary Care Physician: _____ Phone: ( ) _____-_____

Primary Insurance:_____ Insured Name:_____

Group #:_____ Policy #:_____

Emergency Contact: _____Phone: ( ) _____-_____

Are you receiving or have you recently received home health services? Yes No

Are you receiving or have you received other therapy services? Yes No

Please Initial after reading statements:

1. Consent to Treatment: I consent to rehabilitation and related services at Healing Touch Physical therapy & Rehabilitation. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____

2. Treatment of Minor: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

3. Liability: I know and agree that Healing Touch Physical Therapy and Rehabilitation P.C. is not responsible for loss or damage to personal valuables. _____

4. Authorization of Payment: I hereby assign all benefits directly to Healing Touch Physical Therapy and Rehabilitation P. C. and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment. _____

5. Appointment: I understand that I need to inform the office of any cancellations24 hrs prior to any scheduled appointment. There is a mandatory fee of $40 for no shows. The fee must be paid before making any future appointments with us. (Don't be rude and inconsiderate of others who want to make an appointment). _____

Patient Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE

Name _____ ID # _____ Date ____/____/____

In the space below, please describe your major complaint.
Please describe your Current Complaint or Limitation: _____

Please describe how your problem began: _____

Please tell us when your condition started: _____ Specific Date if possible: ___/___/___

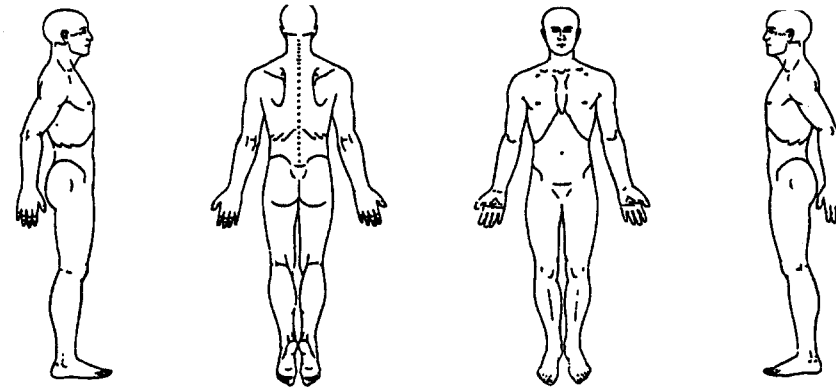
Did you have surgery? ☐ No ☐ Yes Date ____/____/____

Please describe the nature of your pain:

- ☐ Sharp Pain
- ☐ Dull (Pain) Ache
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

- ☐ Constant (76 - 100%)
- ☐ Frequent (51 - 75%)
- ☐ Occasional (26 - 50%)
- ☐ Intermittent (25% or less)

→ → → → → **MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.**



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)**

Since this condition began your symptoms have: ☐ decreased ☐ not changed ☐ increased

Your Symptoms are worse in: ☐ morning ☐ afternoon ☐ night ☐ increased during the day ☐ same all day.

In the past have you been treated for the same problem? ☐ Yes ☐ No

If yes, who did you see for that condition? ☐ MD ☐ Physical Therapist ☐ Occupational Therapist ☐ Chiropractor ☐ Other

When and what treatment did you receive? _____

Occupation _____ Has your work status changed because of this condition ☐ YES ☐ NO

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	HIV /AIDS (042)
☐	☐	Cancer (199.1) Location:_____ Date:_____
☐	☐	Tumor (229.9)
☐	☐	Systemic Lupus (710.0)
☐	☐	Hepatitis (573.3)
☐	☐	Epilepsy (349.5
☐	☐	Diabetes (250.0
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Arthritis (716.9)
☐	☐	Pregnancy
☐	☐	Other_____
☐	☐	Tobacco (305.1) packs/day_____
☐	☐	Drug or Alcohol Dependence (303.9)

Hospitalization/Surgical Procedures (list if not described elsewhere):

_____

_____

Do you have any known allergies: Yes No

If Yes please describe it: _____

_____

Medications: _____

_____

_____

_____

Present: Weight_____ Height_____feet_____in.

Family History: _____

_____

_____

Patient's Signature Date

Healing Touch Physical Therapy & Rehabilitation, PC

1605 Hillside Ave
New Hyde Park, NY 11040
Phone #: 516-616-0942***Fax #: 516-616-0942

Notice of Privacy For Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:
1. to share with other treating health care providers regarding your health care
2. to submit to insurance companies or workers' compensation claim to verify that treatment has been rendered
3. to determine patient's benefits in a health care plan
4. releasing information required by State or Federal Public Health Law
5. to assist in overcoming a language barrier when caring for a patient
6. emergency situations
7. abuse, neglect or domestic violence
8. appointment reminders to household members or answering machines

Any other uses of this disclosure will only be made with your specific written prior authorization.

You have the right to the following:
1. revoke authorization, in writing at any time by specifying what you want restricted and to whom
2. speak to our privacy officer: Jedheesh Peruvingal PT, at the address mentioned above, regarding privacy issues
3. inspect, copy and amend your protected health information and amend it as allowed by law
4. obtain an accounting of disclosures of your protected health information
5. to render a complaint to our privacy officer or the Secretary of Health and Human Services

This office, reserve the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding of the above.

_____
Patient's Name (print)

_____ _____
Patient's Signature/Legal Representative Date