Body 360 PT and Wellness Izabela Beach P.T., PLLC 43 South Street, Manorville, NY 11949 Tel: 631.569.9411

New Client Screen Form

Name	D.O.B				
Address	_ City Zip				
Home # Work #	Cell #				
Email					
Emergency Contact					
Relationship	Phone #				
Primary Doctor	Phone #				
Referral Doctor	Phone #				

PATIENT HEALTH QUESTIONNAIRE

Name:				Dat	e:
1. Please check off who refer MD Office Staff	MD Insur	ance Listing	Friend/Family	Telephone Book	
2. Please describe your curre	nt complaint or li	imitation.———			
3. What is your goal for therap	oy?				
2a. Please describe the nature Sharp Pain Dull Pain/Ache Throbbing Numbness Shooting Burning Tingling	Constant (76 Frequent (51 Occasional (2 Intermittent (2	-75%) 26-50%) 25% or less) where you have		L R R	
4b. Indicate the intensity of your Indicate the intensity of your sector of your sector of the intensity of your sector of the			lo Pain 0 1 2 3 4 lo Pain 0 1 2 3 4		
4c. What movement causes y	our pain to incre	ase?			
2d. Since this condition begar	i, your symptom	s have: decre	ased not change	ed increased	
2e. Your symptoms are worse morning after		ight incre	ease during the day	same all d	ау
4. When did your problem beg 4a. Describe how your proble		days ago r	nonths ago yea	ars ago Date if poss	ible:
5. Did you have surgery?	Yes N	No Date	of surgery if possible	e:	
 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 Nothing Lying		nding Sitti	ng Movement	/Exercise Ina	activity
8. What makes your problem Nothing Lying		nding Sitti	ng Movement	/Exercise Ina	ctivity
9. What is your occupation?9b. Work status changed due9c. What is your current work		F/T n? Yes F/T, no restrictio F/T, with restricti F/T, homemaker	ons P/T, with res		Unemployed Retired Off work due to restrictions

10. Height: _____ Weight: _____

MEDICAL HISTORY QUESTIONNAIRE

Name				DOB		<i>L</i>	Date		
Past Medical History		Are you currently pregnant? Yes No							
<u>Cardiac:</u>		High Blood Pressure Congestive Heart Failur Heart Murmur Other	e	Have you ever had, or do you now have, a head injury or concussion? Yes (date) No <i>Allergies</i> Latex 					r
<u>Respiratory:</u>		Asthma COPD Other			Lotions, c Other		with dates)	
<u>Digestive:</u>		Gastroesophageal Reflu Peptic Ulcer Disease Liver Disease Hemorrhoids Colitis Other	х	Social I Do you If so, ho	History smoke? M w much? _	Yes No		No	
<u>Urinary:</u>		Prostate Enlargement Kidney Stones Urinary Infections Kidney Failure Other		Do you drink alcohol? Yes No If so, how much? Who do you live with? How many stairs are in your home? Any assistive devices in your home? Grab bar in shower Tub bench Grab bar near toilet Hospital bed Dual hand rail for stairs m Describe your job					
Endocrine:		Diabetes Hyperthyroidism or Hy Osteoporosis/ Osteoper Steroids Other							
<u>Hematologic:</u>		Anemia HIV/AIDS Cancer (type) Other		In this job did you use machines, tools, or equipment? Yes No In this job, how many total minutes each day did you do each of th tasks listed:					
<u>Neurologic:</u>		Headaches Stroke		Task Walk	Minutes	Stoop	Minutes	Handle large	Minutes
Vision:		Seizures Other Glaucoma		Stand		over Kneel		objects Write, type, or handle small objects	
		Macular Degeneration Cataracts		Sit		Crouch		Reach	
<u>Psychiatric:</u>		Other Depression Anxiety Eating Disorder Other		Climb Crawl Lifting and carrying (explain what you lifted, how far you carried it and how often you did this in your job.)					
<u>Muscular:</u>		Back Pain Arthritis Rheumatoid Arthritis Other	-	Circle weight frequently lifted? Less than 10 lbs 10 lbs 25 lbs 50 lbs 100 lbs or more Circle heaviest weight lifted? Less than 10 lbs 10 lbs 25 lbs 50 lbs 100 lbs or more					

MEDICATION LIST

Patient Name:_____

D.O.B.:_____

Date:_____

MEDICATION	DOSAGE	X DAILY

Notice of Privacy Practices Acknowledgment

By my signature below, I hereby acknowledge receipt of this Notice of Privacy Practices, and I acknowledge that Body360 PT and Wellness 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 Body360 PT and Wellness restricts how my private information is used or disclosed. I also understand that in providing treatment, submitting bill-ing, and conducting healthcare operations, Body360 PT and Wellness 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

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 Body360 PT and Wellness 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.

OUT OF NETWORK INSURANCE POLICIES

Izabela Beach does not bill insurance companies directly. The patient is expected to pay for therapy sessions and then may apply to their insurance company for reimbursement. Therapy sessions are typically a full hour (more or less as necessary) rather than allocating time for dealing with insurance companies. Receipts are provided using typical physical therapy insurance codes. If you have out of network insurance coverage for outpatient physical therapy, you should be eligible for reimbursement at their standard outpatient rate. Izabela Beach is not an in-network provider, and therefore your reimbursement will most likely be at the insurance company's out of network rate. Please be advised that in the event of a missed, cancellation less than 24-hours prior to scheduled appointment or no-show appointment, there will be a full charge of the session.

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 Body360 PT and Wellness.

HIPAA PRIVACY

I hereby certify that I read and understood 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:_____