

# ACTIVE PHYSICAL THERAPY SOLUTIONS PC

Westlake Ave. Auburn, NY 13021 (315) 515-3117 F: (315) 515-3121

## Patient Information Update Form

Please Print

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

**Patient Health Questionnaire**

1. Describe your present symptom (s)

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

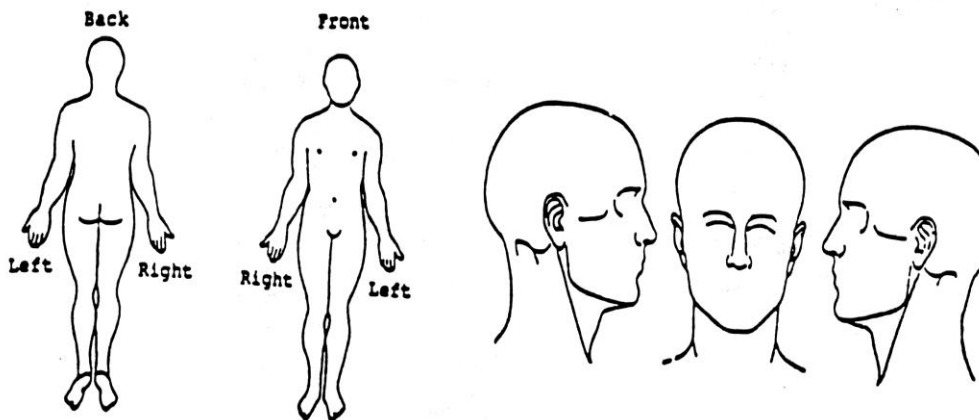
How did your symptom (s) start?

1. Gradual onset, no particular injury
2. Work injury
3. Motor Vehicle accident
4. Sports Injury: Throwing, Swimming, Running, Golf, Tennis, Other \_\_\_\_\_
5. Other

3. When did your symptom (s) start? (day/month/year) \_\_\_\_\_

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

<b>Ache</b>	<b>Burning</b>	<b>Numbness</b>	<b>Pins &amp; Needles</b>	<b>Stabbing</b>	<b>Other</b>
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5. Indicate each symptom's intensity by making a slash along the corresponding line from no pain (left) to worst possible pain (right). Also indicate % of the day present and pattern of change.

Symptoms	No Pain	Worst Pain Possible	% of day present				Getting Better	Not Changing	Getting Worse
			0-25	26-50	51-75	76-100			
____ Headache	_____	_____	1	2	3	4	1	2	3
____ Neck Pain	_____	_____	1	2	3	4	1	2	3
____ Lower back pain	_____	_____	1	2	3	4	1	2	3
____ Upper back pain	_____	_____	1	2	3	4	1	2	3
____ Mid back pain	_____	_____	1	2	3	4	1	2	3
____ Other	_____	_____	1	2	3	4	1	2	3
____ Other	_____	_____	1	2	3	4	1	2	3

6. Indicate which of the following activities make your symptom (s) better (^) or worse (/).

- |                |                        |                           |                         |
|----------------|------------------------|---------------------------|-------------------------|
| ^^ // Sitting  | ^^ // Bending forward  | ^^ // Movement / activity | ^^ // Laying down       |
| ^^ // Standing | ^^ // Bending backward | ^^ // Inactivity          | ^^ // Reaching Overhead |