ACTIVE PHYSICAL THERAPY SOLUTIONS PC

91 Columbus Street, Auburn, NY 13021 T: (315) 515-3117 F: (315) 515-3121

Patient Information Update Form

Date Completed: _____

Name _____ Nickname _____

Sex _____ DOB _____ Age _____

Address _____City, State, Zip_____

Home Phone _____ Cell Phone _____Work Phone _____

Employer _____ Occupation _____

Employer Address _____ City, State, Zip _____

Current work status ____Working: Full- time Part-time Full- duty Light-duty Not working_____

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 _____

Policy # _____ DOB of insured _____

Secondary Insurance Information

Name and Address of Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Employer _____

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

Patient Health Questionnaire

1. Personal Information: Estimated Height: _____ Estimated Weight:_____
2. Describe your present symptom (s)

_____

3. 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

4. When did your symptom (s) start? (day/month/year) _____

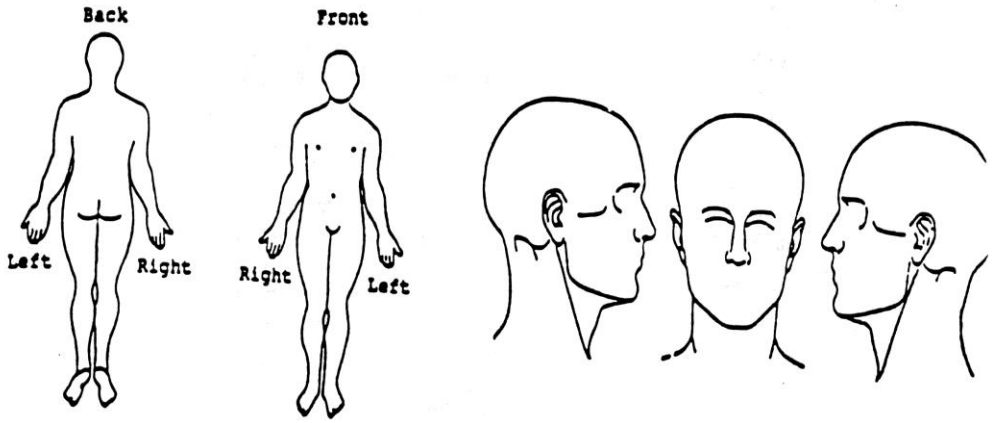
5. Are you currently receiving **<u>any form of home healthcare services?</u>** ☐ Yes ☐ No

   Please explain _____

   ****Please be aware that your insurance will not cover outpatient services and home healthcare services simultaneously.****

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

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^^	======	oooooooo	……	///////	xxxxxxx



7. Indicate each symptom's intensity by making a slash along the corresponding line from no pain (left) to worst possible pain (right).

   No Pain (0)←----------→ (10) Worst Pain

8. Indicate which of the following activities make your symptom (s) better (B) or worse (W).

B W Sitting	B W Bending forward	B W Movement / activity	B W Laying down
B W Standing	B W Bending backward	B W Inactivity	B W Sleep
B W Computer	B W Reaching Overhead	B W Driving	B W Exercise

9. Patient Functional Goals: List (2) Goals you would like to achieve from your treatment
   1. _____
   2. _____

10. Have you fallen 2 or more times in the last 12 months without injury Yes_____ No _____

    Have you fallen 1 time in the last 12 months with injury? Yes _____ No _____