Dear Patient,

Thank you for choosing Active Physical Therapy Solutions for your treatment needs! In an effort to serve you best, we ask that you thoroughly complete the following paperwork. This new patient paperwork serves as a tool to make your initial evaluation as well as your follow up visits with us as efficient and effective as possible. At Active Physical Therapy Solutions, we are devoted to helping you get the answers you need and in order to do so we need as much information about you as possible. We also ask that you please **arrive 20 minutes early** for your initial evaluation so that your therapist can review the paperwork before your scheduled appointment time. Thank you and we look forward to being your ***active solution to achieving your personal goals!***

Sincerely,
Active P.T. Solutions Staff

ACTIVE PHYSICAL THERAPY SOLUTIONS PC

91 Columbus St. Auburn, NY 13021 (315) 515-3117 F: (315) 515-3121

Office Hours: Mon 8:00am-5:30pm, Tues 8:00am-7:00pm, Wed 8:00am-6:00pm, Thurs 8:00am-7:00pm,
Fri 8:00am-5:00pm, Sat 8:00-1:00pm

***In an effort to keep the office running as efficiently as possible, this paperwork needs to be completely filled out when you arrive for your appointment. If it's not complete, your appointment will be rescheduled. We also ask that you arrive 20 minutes early so we can review your paperwork before your appointment. Thank you for your co-operation!**

Patient Information

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 _____

Email Address: _____

Marital Status ____Married Single Separated Divorced Widowed Other ____ _____

Primary Insurance Information

Name and Address of Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Employer_____ DOB of insured_____

Policy # _____

Secondary Insurance Information

Name and Address of Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Employer_____ DOB of insured_____

Policy # _____

Primary Doctor Information

Primary Doctor Name _____ Phone #_____

Doctor's Address_____

Date of last visit_____

Review of Systems Family - Personal - Medical Histories

Patient Name: _____ Date: _____

Please mark any condition or symptoms you have had in the past or are currently experiencing.

Family History	**Your General History**	**Endocrine System**	**Eye/Ear/Nose/Throat**
___ Diabetes ___ Thyroid disease ___ Tuberculosis ___ Kidney disease ___ High blood pressure ___ Heart disease / stroke ___ Musculoskeletal disease ___ Cancer ___ Other	___ Trauma/Injuries ___ Height Change ___ Fever/Chills ___ Sweats ___ Malaise/fatigue ___ Weakness ___ Cancer	___ Heat / Cold intolerance ___ Thyroid problems ___ Hypo ___ Hyper ___ Diabetes ___ Type I (Juvenile) ___ Type II (Adult) ___ Neck surgery / irradiation ___ Adrenal Fatigue	___ Visual problems ___ Eye irritations ___ Pain in the eyes ___ Other eye problems ___ Difficulty hearing / deaf ___ Ringing in ears / dizziness ___ Ear growth / discharge ___ Ear pain ___ Vertigo

Eye/Ear/Nose/Throat (cont)	**Cardiovascular System**	**Cardiovascular System (cont)**	**Gastrointestinal System**
___ Nose bleeds ___ Change in ability to smell ___ Sneezing ___Nose growths / discharge ___ Nose pain ___ Sinusitis	___ Shortness of breath ___ Chest discomfort / pain ___ Sudden calf pain/while walking	___ High blood pressure ___ Past heart disease ___ Rheumatic fever ___ Pacemaker ___ Anemia ___ Bruise Easily	___ Change in appetite ___Food intolerance ___ Nausea / Vomiting ___ Vomiting of blood ___ Peptic Ulcer ___ Indigestion / Heartburn ___ Abdominal pain ___ Abdominal swelling ___ Gas ___ Change in stool/color/etc.

Gastrointestinal System (cont)	**Urinary System**	**Urinary System (cont)**	**Respiratory System (cont)**
___ Constipation ___ Diarrhea ___ Hernia ___ Hemorrhoids ___ Gallbladder disease ___ Pancreatitis ___ Alcohol intake ___ Type _____ ___ Amount_____ ___ GERD ___ IBS ___ Crohn's Disease ___ Celiac Disease	___ Frequent urination ___ Day/ _____ night ___ Daily fluid intake _____ ___ Pain on urination ___ Change in urine color / etc ___ Difficulty in starting stream ___ Difficulty in holding urine ___ Discharge ___ Flank pain	___ Urinary tract infections ___ Kidney disease ___ Pelvic pain ___ Other problems **Respiratory System** ___ Difficulty in breathing ___ Cough ___ Blood in sputum ___ Wheezing/asthma	___ Tuberculosis / exposure ___ Pneumonia / lung infections ___ Cigarette smoking history Daily # _____, yrs ___ ___ Other tobacco use Cigar _____ Pipe ____ Chewing tobacco _____ Amount _____ yrs____ Environmental exposure Type _____ Amount _____ ___ Seasonal Allergies

Please mark any condition or symptoms you have had in the past or are currently experiencing.

Neurological System	**Musculoskeletal**	**Breast**	**Diet / Vitamins**
___ Headaches ___ Epileptic seizures ___ Tics / spasm ___ Dizziness / fainting ___ Disturbances of sensation ___ Unusual weakness ___ Head trauma ___ Stroke ___ History of Concussion ___ Other problems	___ Joint stiffness / decreased motion ___ Joint pain ___ Joint swelling ___ Muscle cramps ___ Muscle weakness ___ Muscle wasting ___ Neck pain ___ Mid back pain ___ Low back pain	___ Bumps / lumps / mass ___ Pain / tenderness ___ Dimples in breast ___Change in color, size or shape ___ Nipple discharge ___ Other breast problems ___ Breast implants	___ Vegetarian ___ Take Supplements _____ **Implants** ___ Cardiac pacemaker ___ Penile / other _____

Skin / Hair / Nails	**Musculoskeletal**	**Reproductive System**	**Female Patients**
___ Change in skin texture ___ Change in skin temp ___ Skin dryness / wetness ___ Unusual skin coloration ___ Rashes / itching / sores ___ Skin growths	___ Sacroiliac pain ___ Tailbone pain ___ Arm problem ___ Leg pain ___ Fracture / dislocations ___ Sprain / strains ___ Other injuries or problems	___ Genital lesions / sores ___Genital mass / growth / pain ___ Syphilis ___ HIV positive ___ Gonorrhea ___ Change in sex drive ___ Birth control method Type_____ How long? _____	___ 1st period Age _____ Yr _____ ___ Light flow ___ Moderate flow ___ Heavy flow ___ Pain 0 1 2 3 4 5 ___ First day of last cycle _____ Date of last pap _____

Skin / Hair / Nails	**Psychological History**	**Diet / Vitamins**	**Female Patients Menopause**
___ Mole growths ___ Skin cancer ___ Skin pain ___ Change in hair texture / condition ___ Change in hair growth / loss ___ Change in shape of finger / toenails ___ Change in nail color ___ Other problems ___ Lipoma	___ Anxiety ___ Depression ___ Hospitalization ___ Therapy ___ Bipolar Disorder **Hospitalization / Meds** ___ Other hospitalizations not listed above ___ Current use of any drugs, prescription or recreational	___ Do you skip breakfast? ___ Eat junk food ___ On a special diet ___ Gluten Free ___ Dairy Free ___ Non GMO ___ Probiotics	___ Post menopause bleeding ___ Abdominal pain ___ Premenstrual fluid retention ___ # of pregnancies ___ # of children ___Difficult delivery ___ PMS syndrome ___ Hysterectomy Date _____

Patient Signature _____ Date _____

Patient Health Questionnaire

1. Personal information: Estimated Height: _____ 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: ☐Car/Truck ☐ Motorcycle ☐ ATV ☐Boat/Jet Ski ☐ Snowmobile
4. Sports Injury: Throwing, Swimming, Running, Golf, Tennis, Other _____

4. **When did your symptom(s) start?** (day/month/year) _____
(If Work Comp or No Fault, Date of Injury or accident is required)

5. Have you ever had Physical Therapy or Chiro for these symptoms? ☐ Yes ☐ No Initials of Patient _____

If so, where did you go and how long did you attend? _____

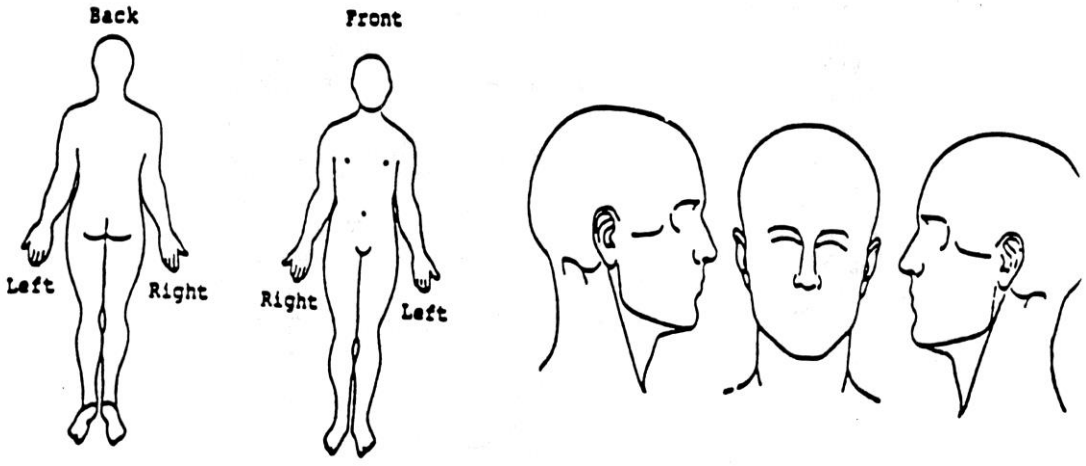
6. Are you currently receiving **any form of home healthcare services?** ☐ Yes ☐ No

Please explain _____

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

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

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



8. 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

9. 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

10. Patient Functional Goals: List (3) Goals you would like to achieve from your treatment

1. _____
2. _____
3. _____

11. 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 _____

12. If you have ever had **ANY** surgical procedures, please list to the best of your ability below:

☐ If you are denying ever having a previous surgical procedure, please check box and initial. _____

Name of Procedure	Date performed	Condition performed for

13. Legal and insurance information:

Is this a work related injury? 1. No 2. Yes Initials of Patient _____

Did this injury happen at school? 1. No 2. Yes Initials of Patient _____

Will APTS be billing the school's insurance? 1. No 2. Yes Initials of Patient _____

Did this injury occur in a Motor Vehicle Accident? 1. No 2. Yes Initials of Patient _____

If this injury occurred in an MVA or at work and we are not billing WC or MVA please explain.

_____

Are you currently or, do you anticipate being involved in any litigation relating to your symptom(s)?

1. No 2. Yes

14. Who filled out this questionnaire?

1. Patient without help from others
2. Patient with help from family/friends
3. Family member or friend of patient
4. Health care provider during the history
5. Other

15. What made you decide to choose Active Physical Therapy Solutions for your Physical Therapy and/or Chiropractic needs?

Please check the appropriate box and explain.

☐ Active P.T. Solutions Employee _____ ☐ Physician_____

☐ Patient _____ ☐ Friend/Relative _____

☐ Newspaper Ad/Article _____ ☐ Billboard/Signage _____

☐ Website _____ ☐ Other _____

Policies & Procedures

Authorization for Medical Information Release

I authorize Active Physical Therapy Solutions PC to furnish my insurance company with medical information they may request regarding my condition or treatment. I authorize my referring health care provider to release any diagnostic reports and/or surgery reports to Active Physical Therapy Solutions PC. Furthermore, I authorize Active Physical Therapy Solutions PC to release any treatment reports to the referring physician as it corresponds with the physical therapy prescription.

Authorization of Treatment

I hereby authorize treatment of the below-named patient by Active Physical Therapy Solutions PC.

I understand that any patients under the age of 18 **must be accompanied to the initial physical therapy or chiropractic evaluation by the parent or legal guardian of the patient.** Failure to comply may result in rescheduling your appointment.

Privacy Notice & Patient Bill of Rights

I have read and understand Active Physical Therapy Solutions PC Notice of Privacy Practices and Patient Bill of Rights.

I certify that I am 18 years of age and/or the legal guardian/guarantor of the patient named below.

Designated person(s) to aid in patient care or to communicate medical information in the case of an emergency:

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

Printed Name of Patient _____**Date**_____

Signature of Patient and/or Legal Guardian_____

Current Medication List

*Must include medication name, dosage, frequency, and route of administration to **satisfy insurance requirements***

Patient Name: ____ Date: ____________________

Name	Dosage	Frequency (circle one)	Route (circle one)
Prescription Medication:			
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
Over the Counter Medication (Advil, Aleve, etc.):			
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: __________

continued on next page →

Name	Dosage	Frequency (circle one)	Route (circle one)
Vitamin/Mineral/Dietary Supplements (Multivitamins, Vitamin C, etc.):			
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
Herbals (Echinacea, Saw Palmetto, Gingko Biloba, etc.):			
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________

Financial Agreement

Please write your initials after **EVERY** statement.

I am responsible for making sure that Active Physical Therapy Solutions PC has accurate insurance information for each date of service at the time services are rendered. If I fail to comply, I am responsible for all denied services. _____

If my insurance policy allows a certain number of visits for physical therapy or chiropractic services, I am responsible for tracking those visits as well as payment for any treatment given past that allowance. _____

I agree to be fully responsible for any services deemed as non-covered or denied by my insurance company for contractual reasons for each episode of care at Active PT Solutions. _____

I recognize and accept complete financial responsibility for any balance remaining after the payment of correct benefits by an insurance company. _____

I understand that I'm responsible for verifying that Active Physical Therapy Solutions PC is in-network with my insurance. Active Physical Therapy Solutions PC will bill **out-of-network** but, I understand that I am responsible for the remaining balance after Active Physical Therapy Solutions PC accepts the out of network payment by my insurance company and I agree to pay for any denied or unpaid services rendered by Active Physical Therapy Solutions PC. _____

If I am **uninsured**, or become uninsured during the course of treatment, I understand that I am responsible for payment in full at the time of service, unless prior arrangements have been made with the Associate Director of the office. _____

I assign insurance benefits for all services rendered by permitting payment directly to Active Physical Therapy Solutions PC, for services rendered. _____

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below.

Printed Name of Patient _____ **Date**_____

Signature of Patient and/or Legal Guardian_____

Cancellation Policy

The success of your treatment is important to us. In order to have a successful treatment plan your attendance is imperative. In an effort to accommodate the treatment schedule for all patients, we request that you call at least 24 hours prior to your appointment to cancel or reschedule**. If you cancel or no show two or more consecutive appointments, your future appointments will be cancelled without notice** and a $25 fee will be assessed in order to reschedule an appointment. Active Physical Therapy Solutions reserves the right to waive such fees as a courtesy in the event of severe weather, health emergencies and special circumstances. **This fee is not reimbursable by your insurance carrier and is due before you will be treated again.**

Please feel free to discuss any questions or concerns with the Associate Director of Active Physical Therapy Solutions PC and thank you for your cooperation on this very important matter!

I have read, understand and agree to the Active Physical Therapy Solutions PC cancellation Policy. It has been explained to me and my questions have been answered to my satisfaction.

Printed Name of Patient _____ **Date** _____

Signature of Patient and/or Legal Guardian _____