Personal Information;

Patient Name: _____

DOB: _____ SSN: _____

Insured Name: _____

Phone#: (Home) _____(Cell)_____

Email address: _____

Home Address: _____

_____

Would you like to receive our free monthly Newsletter via email? ☐Yes ☐No

Emergency contact (REQUIRED);

Name and Number(s):_____

History of Physical Therapy/Occupational Therapy;

Have you received physical or occupational therapy in the last year?

Yes No

Where and When? _____

_____

Prescription for Physical Therapy/Occupational Therapy;

Do you have a prescription for PT or OT? Yes No

How did you hear about our facility?

Doctor: _____

Friend: _____

Media:_____

Other: _____

Referring physician;

Name: _____

Phone#: _____

Billing;

Primary Insurance: _____

Member #:_____

Secondary Insurance: _____

Member #:_____

Dated: _____

Signature: _____

PHYSICAL THERAPY PRE-EXAM QUESTIONNAIRE

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. What is your age? _____
2. What is your gender? ¤ Male ¤ Female
3. What is your occupation? _____
   -Are you working now? ¤ Yes ¤ No
4. Have you had physical therapy before? ¤ Yes ¤ No
5. What is your pain/problem? _____
6. What caused your pain/problem? _____
7. Approximately when did it start? ____/____/ 20____
8. Is it getting worse, better, or staying the same?

   _____
9. Have you ever had this problem/pain before? ¤ Yes ¤ No
10. Is your pain constant (never goes away)? ¤ Yes ¤ No
11. On the scale below circle your worst pain level in the past couple of days:

    Mild Moderate Severe

    0... 1... 2... 3... 4... 5... 6... 7... 8... 9... 10
12. Are you taking any medication for this pain/problem? ¤ Yes ¤ No

    If yes, what and does it help?

    _____
13. Are any of your usual everyday activities affected? ¤ Yes ¤ No
14. List all past surgeries with dates:

    _____
15. List all medical conditions you have (or were told you have)?

    _____

    _____

Patient Name: _____

Signature: _____ Date: _____

STATE OF THE ART PHYSICAL THERAPY REHAB. P.C

Name :_____ Date:_____

MEDICAL HISTORY

Self	Family	Condition	Self	Family	Condition
		Aorta aneurism			Diabetes
		High Blood Pressure			Epilepsy
		Angina			Ulcer
		Heart Attack			Kidney Disorder
		Pacemaker			Bladder Infection
		Stroke			Irritable Colon
		Asthma			Prostate Problems
		Emphysema			HIV/Aids
		Tumors/Cysts			Rheumatoid Arthritis
		Anorexia/Bulimia			Heart Problems
		Blood Disorders			Lung Problems
		Osteoporosis			Back Problems
		Broken Bones			Headaches
		Cancer			Neck/Back Injury
		Arthritis			Lupus

Please circle any of the following that apply

Tobacco Use YES/NO (If yes, how much did/do you smoke?) _____

Alcohol Use YES/NO (If yes, how much did/do you drink?) _____

Pregnant Yes/NO

STATE OF THE ART PHYSICAL THERAPY REHABILITATION, P.C.

Dr. Emilian Emeagwali, PT, MCMT
31 East Merrick Road, Valley Stream, NY 11580
Phone: (516) 612-4400 ® Fax: (516) 612-4399

NOTICE TO OUR PATIENTS

Although we participate with many insurance plans, it is your responsibility to be sure that we are a participating provider in your plan as there are some plans that do not cover physical therapy services.

It is also your responsibility to understand the limits of your insurance as you are responsible for all charges whether or not paid by your insurance.

Thank you in advance for your cooperation.

Name: _____

Signature: _____ Date: _____