"Dedicated to Excellence in Patient Care"

Welcome to North Island Physical Therapy!

We at NIPT are committed to delivering the highest quality rehabilitation and health care, with goals of minimizing pain, maximizing efficient movement and restoring your function. We view your rehabilitation as a partnership. As such, your commitment to regular attendance and your compliancy to an individualized home exercise program are vital to the success of you treatment.

We greatly appreciate your commitment to your physical therapy program and thank you, in advance, for you cooperation in your successful rehabilitation.

If you have any questions, please do not hesitate to ask.

Thank you.

I have read the above statement and agree: __________ Initial

Sincerely,

The NIPT Staff

2500 Nesconset Hwy., Bldg. 22B Stony Brook, NY 11790 • Tel: 631-751-7988 • Fax: 631-751-7989
Web: http://www.northislandpt.com • email: northislandpt@yahoo.com

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Patient Information Form

Name____

Home Phone #_____________________ Cell # ____________________

Address______________________ City______________ Zip________

Date of Birth____________________ Social Security #________________

Email____

Employer______________________ Work phone #_________________

Spouse's Name____________________ Work phone #_______________

Nearest relative not living with you________________ Phone #____________

Physician_____________________ Phone #____________________

Dentist (TMJ only)__________________ Phone #________________

Emergency contact__________________ Phone #________________

Whom may we thank for referring you?_______________ Phone #___________

Who is financially responsible for this bill?______________________________

Have you had physical therapy this year?_______ how many visits?____________

Please complete one of the following insurance information: General, No Fault, or Workman's Compensation

General Insurance Information:

Primary Insurance Company___________________________________
Billing address___________________________________
ID #____________________ Phone number____________________
Secondary Insurance___________________________________
ID #___________________________________

No Fault:

Insurance Company Name & Address___________________________________
____
Adjuster's Name ____________________ Phone #____________________
Case/Claim #____________________ Date of injury____________________

Workman's Compensation:

Insurance Company Name & Address___________________________________
____
Adjuster's Name____________________ Phone #____________________
Case/Claim #____________________ Date of Injury____________________
Employer's name___________________________________

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status of the above information.

____________________________________ Date____________________
Signature

____________________________________ Date____________________
Parent (if minor)

North Island PHYSICAL THERAPY, PC

Medical History Questionnaire Form

Patient Name:	Date:
Occupation:	Age:

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. THE THERAPIST WILL REVIEW YOUR RESPONSES WITH YOU.

Height:	Current Weight:	Gain/Loss Over Past Year:

Present Condition, Pain or Tension:

1. Please mark on diagram and list symptoms below that you are experiencing and rate each on a scale of 0 to 10. (Key: 0 = no pain and 10 = worst pain ever experienced)

Symptoms	Severity
A.	0 1 2 3 4 5 6 7 8 9 10
B.	0 1 2 3 4 5 6 7 8 9 10

2. Since its initiation, has the pain changed? ____________________

3. How often do you experience the pain? ____________________

4. What do you think initially caused your pain? ____________________

5. Have you ever had these symptoms before? If yes, when: ____________________

North Island Physical Therapy Medical History Questionnaire

Your physical therapist must have a thorough understanding of your medical history to treat you to the best of their ability. Please Circle **Yes** or **No** for **ALL** of the following.

Do you currently have, or have you had in the past:

Cardiac problems such as Heart disease, High Blood Pressure, Congestive Heart Failure, Pacemaker, Heart Attack, Coronary Bypass Surgery, etc.	Yes	No
Peripheral Artery Disease	Yes	No
History of Blood clots	Yes	No
- Do you taken Coumadin (Blood thinners) regularly	Yes	No
Breathing problems, such as COPD, Asthma, Pneumonia or Emphysema	Yes	No
Diabetes	Yes	No
- Do you inject insulin	Yes	No
Cancer	Yes	No
- Type/Location/Year Diagnosed/Treatment ______________________		
Neurological disorders, such as Parkinson's disease, Multiple Sclerosis, seizure disorder, history of a Stroke, etc.	Yes	No
Head Injury (if yes, list date(s)______________)	Yes	No
Frequent headaches	Yes	No
-Please circle frequency: Daily, Weekly, Monthly		
Peripheral Neuropathy	Yes	No
Autoimmune disorders, such as Rheumatoid Arthritis, Lupus, Sarcoidosis, Crohn's disease, etc.	Yes	No
Osteoporosis/Osteopenia	Yes	No
History of Orthopedic conditions such as osteoarthritis, broken bones, joint injuries, herniated discs or neck/low back pain (if yes, list below)	Yes	No
-Location______________________		
Disorders that affect your mood	Yes	No
Pain at night	Yes	No
Are you pregnant, or could you be pregnant	Yes	No

Please List **ANY** other medical conditions you may have which are not included in the above list.

____

____

Please List **ALL** Surgeries you have had, including dates and locations.

____

____

Please List **ALL** medications you are currently taking.

____

____

Please list **ANY** allergies you have.

____

____

Are you currently under the care of physician, psychiatrist, or other health care professional other than the one who prescribed you to physical therapy?

☐ Yes ☐ No ______________________________

Have you ever had physical therapy previous to this occasion? If yes, please explain for what problem, how much therapy and when:

____

____

I certify that the above information is accurate to the best of my knowledge.

______________________________ ______________________________

Patient Signature Physical Therapist Signature

North Island Physical Therapy

Goals Sheet:

Becoming Pain-Free Starts Here!

One of the most important steps in your journey toward a pain-free life is writing down your goals for a healthy lifestyle. List the activities to which you would like to return, as well as any activity goals you would like to achieve.

Are there any activities you have stopped doing because of pain? Is your pain or lack of physical fitness restricting your exercise or activity goals?

****Example:** 1. Being pain-free and walking 1 - 2 miles 3xs/week.

2. Running a 5K pain-free

Write your goals down here and speak to your Physical Therapist re: a plan on how you will meet each goal.

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

Signature: ______________________ **Date:** __________

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Patient Appointment Cancellation Policy

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being is taken very seriously.

Your adherence to the recommended number of treatments is a vital component of your progress with your physical therapy. Therefore, it is necessary for you to conform to our office policy regarding cancellations and missed appointments.

With the exceptions of illness or serious emergencies, it is expected that you keep all your scheduled appointments. If you do need to reschedule, we require 24hours notice. In that case, please call our office as early as possible to reschedule your appointment with our front desk.

In the case of a missed or cancelled appointment, we reserve the right to charge a **$25.00 cancellation fee**.

In cases of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your referring physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We greatly appreciate your cooperation.

Mark C. Marino, MA, PT, CFMT
Owner/Director
North Island Physical Therapy, PC

I have read and fully understand this policy.

Signature_______________________________________Date________________

Print Name____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of NORTH ISLAND PHYSICAL THERAPY's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____

____

____

Signed:______________________________ **Date:**__________________________

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: ___________________ **Witnesses by:**_________________________

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time):______________________________________

By: (name and title): ____