Hands-On Physical Therapy
32-44 31st
Astoria NY, 11106
718-626-2699
pt@handsonpt.org
www.handsonpt.org

1. PHYSICIAN

First Name _____ Last Name _____

Adreess _____

Phone # _____ Specialty _____

Primary Care Physician
○ Yes ○ No

2. EMPLOYER

Employer's Name _____

Employer's Adreess _____

Occupation _____

3. SPOUSE'S EMPLOYER

Employer's Name _____

Employer's Adreess _____

Occupation _____

4. PAYER RESPONSIBILITY

PAYER
☐ Insurance ☐ Self ☐ Worker's Compensation (WC) ☐ No Fault (NF)

Primary Insurance Company: _____ Phone # _____

Subscriber's Social Security # _____ Group #: _____ ID#: _____

Address: _____

Whose name is this insurance under?

Secondary Insurance Company (If Any): Phone #

Subscriber's Social Security Group #: ID#:

Whose name is this insurance under?

Worker's Compensation/No-Fault Insurance Carrier (WC)/(NF)

WC/NF Claim # Type Of Injury (On The Job?)

Name Of Adjustor Phone #

Attorney's Name Attorney's Phone #

Date Of Accident

5. HOW DID YOU HEAR ABOUT US?

- ○ Doctor's referral
- ○ Family/friend's referral
- ○ Insurance Directory
- ○ Twitter
- ○ Google
- ○ Returning Patient
- ○ Website
- ○ Facebook
- ○ Linkedin
- ○ Walk-In / Near By

6. MEDICAL HISTORY 1 Please mark the following if you have had:

- ☐ Alergies
- ☐ Artificial joints, pins, etc.
- ☐ Cancer
- ☐ Circulatory problems
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Joint Strains
- ☐ Liver disease
- ☐ Muscle Strains
- ☐ Radiation treatment
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Whiplash Injury
- ☐ Angina
- ☐ Asthma
- ☐ Chemical dependency
- ☐ Congenital heart lesions
- ☐ Fractures
- ☐ Heart Surgery
- ☐ High blood pressure
- ☐ Jaw pain
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Respiratory disease
- ☐ Swelling of feet or ankles
- ☐ Tumors
- ☐ Arthritis, rheumatism
- ☐ Blood disease
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Gastrointestinal Problems
- ☐ Hemophilia
- ☐ HIV AIDS
- ☐ Kidney disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Sexually transmitted disease
- ☐ Thyroid problems
- ☐ Ulcer

7. MEDICAL HISTORY 2 Check the following boxes if you have recently experienced:

- ☐ Balance problems
- ☐ Blurred/double vision
- ☐ Change in bowel and bladder habits
- ☐ Constant pain unreilieved by rest/movement
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Falls
- ☐ Headaches
- ☐ Muscular pain with exertion
- ☐ Muscular pain at rest
- ☐ Pain with caughing or sneezing
- ☐ Shortness of breath
- ☐ Tingling numbness or loss of feeling
- ☐ Tremors
- ☐ Unexplained weight loss
- ☐ Unusual skin cloration
- ☐ Unusual fatique
- ☐ Unusual weakness

8. MEDICAL HISTORY 3

Please list any major surguries and hospitalizations _____ Date _____

Do you smoke?
☐ Yes ☐ No

Are you pregnant?
☐ Yes ☐ No

Are you alergic to any medication
☐ Yes ☐ No

If yes list the medication that you alergic to _____

Is this problem due to an injury?
☐ Work Related ☐ A motor Vehicle Accident ☐ Other

Did you have any of following diagnostic tests?
☐ X-Rays ☐ MRI ☐ EMG/NCV ☐ MSK Ultra Sound

Date was performed

_____

Results

_____

9. FALLS

Have You Fallen In The Past 12 Months?
☐ YES ☐ NO

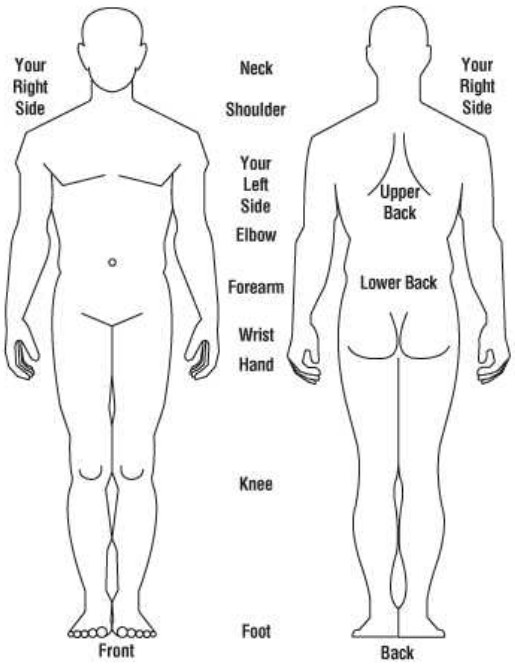
If Yes, what is the number of falls in the past 12 months? _____ Date of most recent fall: _____

10. FALLS EFFICACY SCALE: Please rate each of the following tasks from 1 (easy) to 10 (extremely difficult).

	1	2	3	4	5	6	7	8	9	10
Take a bath or shower:										
Reach into cabinets or closets:										
Walk around the house:										
Prepare meals not requiring carrying heavy or hot objects:										
Get in and out of bed:										
Answer the door or telephone:										
Get in and out of chair:										
Getting dressed and udressed:										
Personal Grooming (ie washing your face):										

11. PLEASE UPLOAD A COPY OF YOUR LATEST X-RAY, MRI, EMG OR ANY OTHER RELATED TO YOUR PROBLEM REPORT.

12.BODY CHART: Mark the areas where you feel the symptoms with the use of the Computer's mouse:



13. **ELECTROMYOGRAPHY & NERVE CONDUCTION TESTING SCREENING TOOL If you currently feel or have felt any of the following symptoms within the past month or if you have been diagnosed with any of the following conditions, please check the appropriate boxes. This is a screening tool that can help your Doctor determine if EMG/NCS Testing (ElectroMyoGraphy & Nerve Conduction Testing) is right for you.**

- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Burning Sensation
- ☐ Weakness In The Arms
- ☐ You Are Diabetic
- ☐ Muscle Weakness
- ☐ Radiating Pain In The Arm
- ☐ You have Neuropathy
- ☐ Numbness Tingling In Legs
- ☐ Numbness Tingling In Feet
- ☐ Numbness Tingling In Hands
- ☐ Weakness In Legs
- ☐ Loss Of Sensation In Hands
- ☐ Loss Of Sensation In Feet
- ☐ Radiating Pain In The Leg
- ☐ Pins And Needles Sensation

14. **HOW LONG HAVE YOU HAD THIS CONDITION?**

15. **HOW DOES IT IMPACT YOUR QUALITY OF LIFE?**

16. **HAVE YOU SEEN A PHYSICIAN OR OTHER HEALTH PRACTITIONER ABOUT THIS? IF YES, WHEN? WHAT WAS THE DIAGNOSIS (IF ANY)?**

17. **DESCRIBE ANY TREATMENT YOU RECEIVED AND THE RESULTS:**

18. **HOW HAVE YOUR SYMPTOMS CHANGED?:**

- ○ Getting Better
- ○ About The Same
- ○ Getting Worse

19. **WHAT AGGRAVATES THIS CONDITION?**

20. WHAT IMPROVES THIS CONDITION?

21. WHAT DO YOU BELIEVE IS CAUSING YOUR CONDITION?

22. HOW WOULD YOU DESCRIBE YOUR GENERAL STATE OF HEALTH?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

23. EMOTIONAL STRESS SCALE:

0 - No stress / 10 - Extremely stressed

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

24. PLEASE LIST ALL CURRENT MEDICATIONS (PRESCRIPTION, OVER-THE-COUNTER, VITAMINS) AND SPECIFY THE DOSAGE.

	Medication	Dosage
1		
2		
3		

Signature _____ Date _____