



**PHYSICAL THERAPY SERVICES OF ROCHESTER, P.C.**  
540 White Spruce Boulevard, Rochester, NY 14623  
(585) 427-7190 FAX: (585) 427-2287

## PATIENT INFORMATION FORM

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone: Home # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_ \ \_\_\_\_ \ \_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(optional)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Reason for therapy: \_\_\_\_\_ Date of onset/injury/surgery: \_\_\_\_\_

Is this a work-related injury?  Yes  No If yes, when? \_\_\_\_\_

Have you seen a physical therapist this year?  Yes  No If yes, how many visits this year? \_\_\_\_\_

Are you seeing a chiropractor?  Yes  No If yes, how many visits this year? \_\_\_\_\_

For what? \_\_\_\_\_

May we obtain relevant x-ray/MRI/CT scan/reports?  Yes  No

How did you hear about Physical Therapy services of Rochester?  Doctor  Friend/Family  Other

If other, please specify: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

*I certify that the above information is correct to the best of my knowledge. I understand and agree that I am personally responsible for full payment of all physical therapy services rendered to me. I hereby transfer/assign payment of any physical therapy insurance benefits directly to Physical Therapy services of Rochester, P.C. and authorize release of any information regarding my treatment that is required by my insurance carrier to obtain such a payment.*

**Please note: a \$50 fee for cancellations without a 24-hour notice or no shows.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Guardian)



HEALTH QUESTIONNAIRE

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Please check **ALL** that apply to your medical history:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cancer: (type)_____           | <input type="checkbox"/> Arthritis: (type)_____             | Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Osteoporosis                       | <input type="checkbox"/> Incontinence                              |
| <input type="checkbox"/> Cardiac Condition             | <input type="checkbox"/> Headaches: (type)_____             | <input type="checkbox"/> Vision Impaired                           |
| <input type="checkbox"/> Pacemaker                     | <input type="checkbox"/> Dizziness: (type)_____             | <input type="checkbox"/> Hearing Impaired                          |
| <input type="checkbox"/> Diabetes: (type)_____         | <input type="checkbox"/> Joint Replacement: (location)_____ | <input type="checkbox"/> Smoker                                    |
| <input type="checkbox"/> Neurologic: (type)_____       | <input type="checkbox"/> Metal Implants: (location)_____    | <input type="checkbox"/> Allergies: (type)_____                    |
| <input type="checkbox"/> Stroke                        | <input type="checkbox"/> Respiratory Condition: (type)_____ | <input type="checkbox"/> Recurrent Fever/Chills                    |
| <input type="checkbox"/> Vascular Problem: (type)_____ | <input type="checkbox"/> Accident/Trauma: (date)_____       | <input type="checkbox"/> Intestinal Problem: (type)_____           |

If further explanation required on any of the above, please use this space:

\_\_\_\_\_  
\_\_\_\_\_

Recent/Relevant Surgeries: \_\_\_\_\_

Do you presently take medication?  Yes  No If yes, please fill out list or attach your own:

Medication/Supplement/Vitamin Name:	Dose:	Frequency:	Diagnosis Taken For:
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Guardian)