**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? qYes qNo If yes, when? _____

Have you seen a physical therapist this year? qYes qNo If yes, how many visits this year? _____

Are you seeing a chiropractor? qYes qNo If yes, how many visits this year? _____

For what? _____

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

How did you hear about Physical Therapy services of Rochester? qDoctor qFriend/Family qOther

If other, please specify: _____

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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.***

 **I agree to pay a $50 fee for cancellations without a 24-hour notice or no shows.**

 **I have received the Notice of Privacy Rights from Physical Therapy Services of Rochester, PC.**

Signature: _____ Date: _____
(Patient/Guardian)

Revised 5/14

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# HEALTH QUESTIONNAIRE

Name: First_____ MI _____ Last _____

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

__ Cancer: (type)_____ __ Arthritis: (type)_____ Pregnant? q Yes q No

__ High Blood Pressure __Osteoporosis __ Incontinence

__ Cardiac Condition __Headaches: (type)_____ __ Vision Impaired

__ Pacemaker __Dizziness: (type)_____ __ Hearing Impaired

__ Diabetes: (type)_____ __ Joint Replacement: (location)_____ __ Smoker

__ Neurologic: (type)_____ __Metal Implants: (location)_____ __ Allergies: (type)_____

__ Stroke __ Respiratory Condition: (type)_____ __ Recurrent Fever/Chills

__ Vascular Problem: (type)_____ __ Accident/Trauma: (date)_____ __ Intestinal Problem: (type)_____

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

_____

_____

Recent/Relevant Surgeries: _____

Do you presently take medication? qYes qNo 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)

Revised 5/14

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# Authorization to Release Information

I, _____, authorize Physical Therapy Services of Rochester, P.C. to release any information regarding my treatment to:

| | |
|---|---|
| _____ | _____ |
| Name | Relationship to Patient |
| _____ | _____ |
| Name | Relationship to Patient |
| _____ | _____ |
| Name | Relationship to Patient |

| | |
|---|---|
| _____ | _____ |
| Patient Signature | Date |