NEW PATIENT QUESTIONNAIRE

Date: _____

Last Name: _____ **First Name:** _____

Street Address: _____ **Email:** _____

Town, State, Zip: _____

Home Phone: _____ **Cell Phone:** _____

Date of Birth: _____ **Martial Status:** _____

Employer Name: _____

Address: _____

Occupation: _____ **Work Phone:** _____

How were you referred to our office? _____

****

Please provide your insurance card to the front desk

Name of Insurance Carrier: _____

Insured's Name: _____ **Insured's Date of Birth:** _____

Insured's Address: _____

Relationship to Insured: SELF [ ] SPOUCE [ ] CHILD [ ] OTHER: _____

****

Major Complaint and Comments: _____

_____

_____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

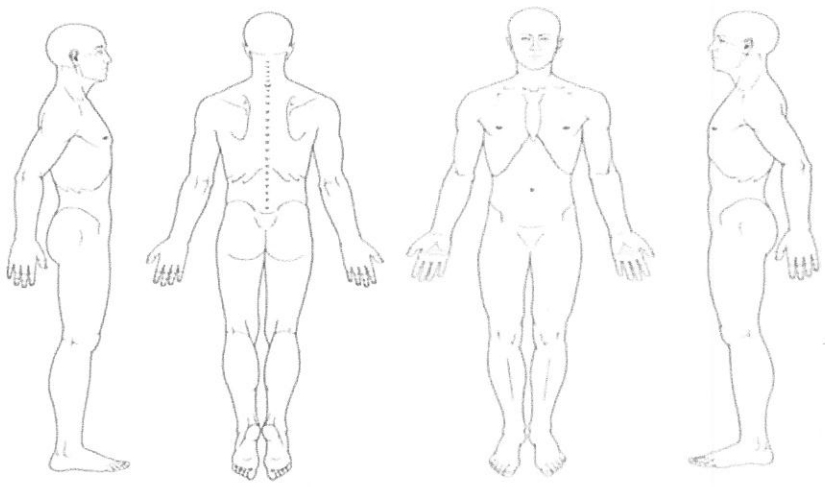
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	

Other Health Problems/Issues

○	○
○	○
○	○

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____

ADVANCED
Physical and Occupational Therapy PLLC.
694 Fort Salonga Rd. (25A)
Suite 2
Northport, New York 11768
Tel: 631-754-3775 Fax: 631-754-3816

PERMISSION FOR TREATMENT

Date: _____

I hereby authorize Advanced Physical and Occupation Therapy PLLC, or its representatives to provide Physical and Occupation Therapy Services. To perform initial evaluations and administer treatments including but not limited to electric stimulation, ultrasound, massage, therapeutic exercise, stretching, etc, to self or my minor child (print name) _____
As may be determined necessary now and on subsequent visits.

Signature: _____ **Print Name:** _____

Relationship: _____

In Case of Emergency Notify

Name: _____

Address: _____

Phone Number: _____

Relationship: _____

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

For Treatments: We may use medical information about you to provide you with medical treatment or services. For Payments: We may use and disclose medical information about you so that the treatments and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. For Heath Care Operations: We may use and disclose health information about you for operation of our health care practice. For Individuals Involved in Your Care or Payment of Your Care: We may release medical information about you to a friend of family member who is involved in your medical care. For Health-Related Services and Treatment Alternatives: We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. As Required by Law: We will disclose medical information about you when required to do so by federal, state, or local law. To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. For Workers Compensation: We may release medical information about you for workers' compensation or similar programs. For Public Health Reasons: We may disclose medical information about you for public health activities. For Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. For Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. For Law Enforcement: We may release medical information if asked to do so by law enforcement officials. For Coroners Medical Examiners and Federal Directors: We may release medical information to the coroner or medical examiner. For National Security and Intelligence Activities: We may release medical information about you to authorized federal officers for intelligence, counterintelligence, and other national security activities authorized by law. For Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations. For Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medial information, you my request in writing, that the denial be reviewed. Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. Your Right to an Accounting of Disclosures: You have the right to request in writing a list accounting for any disclosures of your medical information we have made, expect for use and disclosures for treatment, payment, and health care operations, as perviously described. Your Rights to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request. Your Right to Request Confidential Communications: You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. Your Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We have the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medication information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices

_____ _____

Patient or Personal Representative Signature Date