



Who can we thank for referring you?

We appreciate you choosing Farmingdale Physical Therapy West to be your provider of physical therapy services. If you would not mind, please indicate below how you found out about our clinic. Your cooperation with this survey assists FPTW to better anticipate present and future patient care needs.

Sean C. Serpe,
Practice Administrator

Patient Name: _____

Evaluation Date: _____

I was referred to Farmingdale Physical Therapy West by (please mark an "X" next to the statement below that best describes you):

_____ I am a **returning patient** who was treated previously by Butch Purslow and/or FPTW.

_____ My **primary care provider** referred me to FPTW.

Please print full name of PCP: _____

_____ I was referred by a **specialist provider** (e.g., orthopedic, neurological, sports medicine, no fault, workers compensation)

Please print full name of specialist provider: _____

_____ I was referred by a **family member or friend**.

Please print full name of family member or friend: _____

And family relation if applicable: _____

_____ I learned of FPTW from the **Yellow Pages**.

_____ I learned of FPTW from the **Internet**.

_____ Other: Please describe _____



PRIORITY SURVEY

Patient Name: _____

Evaluation Date: _____

Please mark an "X" next to the statement or statements below that best describes you.

_____ MY INJURY/COMPLAINT IS RELATED TO A **SLIP OR FALL**.

_____ MY INJURY/COMPLAINT IS RELATED TO AN **AUTOMOBILE ACCIDENT**.

_____ MY INJURY/COMPLAINT IS RELATED TO A **WORKPLACE INJURY** (OR AN INJURY WHICH OCCURRED DURING WORK).

_____ I HAVE A **WORKERS COMPENSATION** CLAIM OR CASE.

IF so, case number and carrier: _____.

_____ I HAVE A **NO FAULT** CLAIM OR CASE.

IF so, case number and carrier: _____.

_____ MY INJURY/COMPLAINT IS RELATED TO **SCHOOL OR SPORTS INJURY**.

IF so, case number and carrier: _____.

_____ I HAVE A **PACEMAKER**.

If so, name and telephone number of treating physician (or cardiologist):

_____.

_____ I HAVE RECEIVED PHYSICAL THERAPY AT ANOTHER FACILITY IN THE PAST YEAR.

IF yes, what facility and when: _____.

IF yes, was it for the same injury: _____.

_____ **NONE OF THE ABOVE**



DEMOGRAPHIC INFORMATION

PERSONAL

Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Social Security # _____ - _____ - _____ Home Ph# _____ Cell Ph# _____

Employer _____ Address _____ Ph# _____

Emergency Contact _____ Ph# _____

Relationship _____ E-Mail Address _____

PRIMARY CARE Doctor _____ REFERRING Doctor _____

INSURANCE

Primary _____ Name of Insured _____

Date of Birth _____ Relationship: self _____ spouse _____ child _____ other _____

Social Security # _____ Employer _____ Ph# _____

Secondary _____ Name of Insured _____

Date of Birth _____ Relationship: self _____ spouse _____ child _____ other _____

Social Security # _____ Employer _____ Ph# _____

Are you under chiropractic care for this case? YES / NO

Can patient be called at home? YES / NO

Can messages be left on voicemail? YES / NO

Can patient be called at work? YES / NO

Can messages be left on voicemail at work? YES / NO



DEMOGRAPHIC INFORMATION (continued)

I hereby authorize payment of medical benefits to Henry G. Purslow, P.T., P.C., for services rendered by a licensed physical therapist or physical therapist assistant employed by Henry G. Purslow, P.T., P.C. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request all authorized benefit payments be made on my behalf.

I hereby acknowledge that Henry G. Purslow, P.T., P.C. will add a three (3)% charge on all past due balances, as well as the cost of any collections fees (equal to thirty (30)% of the balance).

In the event of a same day cancellation or no show of a scheduled appointment, Henry G. Purslow, P.T., P.C. reserves the right to charge a \$5 cancellation/no show fee.

PLEASE NOTE: IF YOU DO NOT HAVE A PRESCRIPTION FROM YOUR PHYSICIAN, PODIATRIST, NURSE PRACTICIONER, OR DENTIST, OR IF YOU HAVE BEEN RECEIVING HOMECARE, YOUR PHYSICAL THERAPY VISITS MAY NOT BE COVERED BY INSURANCE.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(If applicable)



MEDICAL HISTORY

Name: _____ Date: _____

Please List:

Past Medical History: _____

Past Surgical History and Date(s): _____

Medical Testing (MRI, CT Scan, X-Ray)

Type: _____ Location/Provider: _____

Date: _____

Type: _____ Location/Provider: _____

Date: _____

Type: _____ Location/Provider: _____

Date: _____



MY MEDICATION RECORD

List prescriptions, over-the-counter drugs, vitamins and herbal medicines.

Patient name: _____ Date: _____

Allergies: _____

Pharmacy name: _____ Phone: (____) _____

Primary doctor name: _____ Phone: (____) _____

Medication name/dose:	Medication treats (condition):	Medication frequency:	Notes/ questions:



HIPAA NOTICE

I, _____, hereby authorize Henry G. Purslow, P.T., P.C., d/b/a/ Farmingdale Physical Therapy West, to use and/or disclose protected health information pursuant to the Notice of Privacy Practices that is posted in this office. I have also been given the opportunity to review and/or receive a copy of these privacy practices.

This authorization shall be in force and effect until such time that I give notification requesting the termination of this authorization.

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the attention of Sean C. Serpe, Privacy Officer at 4277 Hempstead Turnpike, Suite 209A, Bethpage, New York 11714. I understand that a revocation is not effective to the extent that Farmingdale Physical Therapy West has relied on the use of disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal or state law to the extent the state law provides greater access rights, and/or refuse to sign this authorization.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Person(s) we can discuss your care with other than your referring physician:

THIS AUTHORIZATION IS BEING REQUESTED BASED ON THE NEW FEDERAL REGULATIONS THAT BECAME EFFECTIVE OCTOBER 2003 FOR ALL HEALTH CARE PROVIDERS.



COMMUNICATION WAIVER

I, _____ hereby authorize Henry G. Purslow, PT PC d/b/a Farmingdale Physical Therapy West, and its employees, including Henry G. Purslow, Vincenzo Adduci, Erica Allocca and Scott Liptzin to communicate via text messaging and e-mail with me regarding my treatment.

I hereby waive any of my rights under the Health Insurance Portability and Accounting Act of 1996, better known by its abbreviation, HIPAA in connection with any text messages and/or e-mails from Farmingdale Physical Therapy West and its employees. This waiver is not intended as a waiver of any of my other HIPPA rights (unless so stated in another document).

This waiver shall be in force and effect until such time that I give notification requesting the termination of this waiver.

I understand that I have the right to revoke this waiver in writing at any time by sending such written notification to the attention of Sean C. Serpe, Privacy Officer at 4277 Hempstead Turnpike, Suite 209A, Bethpage, New York 11714.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

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Electric Stimulation Pad Policy

Electric Stimulation is a form of treatment that your referring physician and/or physical therapist may find necessary for progress in your treatment plan.

For sanitary reasons, all patients requiring electric stimulation will be responsible for a \$10 fee for a personal set of pads.

Thank you for your cooperation.

Signature: _____ Date: _____



PHYSICAL THERAPY INITIAL EVALUATION FORM

PATIENT INFORMATION

NAME _____ OCCUPATION _____

AGE _____ HEIGHT _____ WEIGHT _____ lbs.

CURRENTLY EMPLOYED? YES NO MODIFIED

REHAB INFORMATION

1. CHIEF COMPLAINT/AILMENT/INJURY

2. DATE OF INJURY _____ DATE OF SURGERY _____

3. BRIEFLY DESCRIBE HOW YOU WERE INJURED.

4. HAVE YOU RECEIVED ANY PHYSICAL THERAPY THIS YEAR? YES NO
IF SO, WHEN? _____

5. HAS YOUR CONDITION BEEN GETTING: WORSE SAME BETTER

6. ARE YOUR SYMPTOMS: CONSTANT OR INTERMITTENT

7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST: 0 1 2 3 4 5 6 7 8 9 10

AT WORST: 0 1 2 3 4 5 6 7 8 9 10

8. WHAT DECREASES YOUR PAIN/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

- | | | | |
|---|-------------------------------------|--|---|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> MOVEMENT | <input type="checkbox"/> REST | <input type="checkbox"/> BETTER IN AM |
| <input type="checkbox"/> SITTING | <input type="checkbox"/> STANDING | <input type="checkbox"/> HEAT | <input type="checkbox"/> BETTER AS DAY PROGRESSES |
| <input type="checkbox"/> RISING | <input type="checkbox"/> WALKING | <input type="checkbox"/> ICE | <input type="checkbox"/> BETTER IN PM |
| <input type="checkbox"/> CHANGING POSITIONS | | | |
| <input type="checkbox"/> LYING | <input type="checkbox"/> MEDICATION | <input type="checkbox"/> N/A CAST JUST REMOVED | |

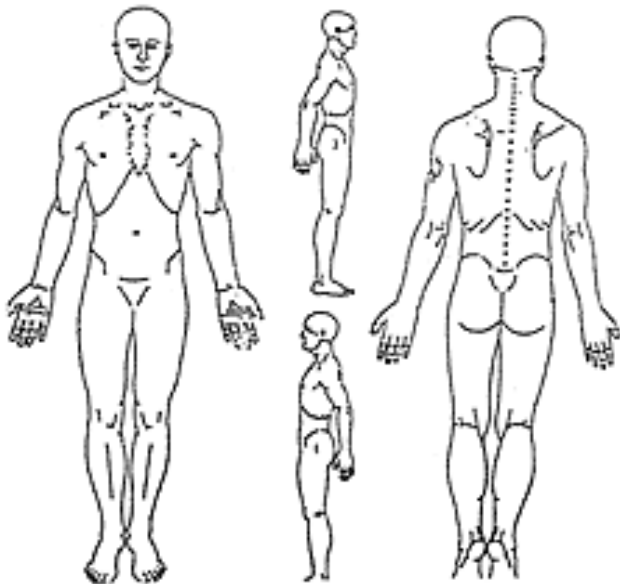
9. WHAT INCREASES YOUR PAIN/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

- | | | | |
|--|-----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> MOVEMENT | <input type="checkbox"/> REST | <input type="checkbox"/> SNEEZE |
| <input type="checkbox"/> SITTING | <input type="checkbox"/> STANDING | <input type="checkbox"/> STAIRS | <input type="checkbox"/> DEEP BREATH |
| <input type="checkbox"/> RISING | <input type="checkbox"/> WALKING | <input type="checkbox"/> COUGH | <input type="checkbox"/> MEDICATION |
| <input type="checkbox"/> PROLONGED POSITIONING | <input type="checkbox"/> LYING | <input type="checkbox"/> WORSE IN AM | <input type="checkbox"/> WORSE IN PM |
| <input type="checkbox"/> WORSE AS DAY PROGRESSES | | <input type="checkbox"/> N/A CAST JUST REMOVED | |



11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

DRAW IN AREAS OF PAIN ON BODY DIAGRAM USING APPROPRIATE SYMBOLS.



- SEVERE PAIN *****
- MODERATE PAIN 00000000000
- DULL ACHE ooooooooo
- RADIATING PAIN ↑↓↑↓↑↓
- NUMBNESS/TINGLING XXXXXXXXXX

MEDICAL INFORMATION (MARK ALL THAT APPLY) **THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART.

- | | | |
|--|--|---|
| <input type="checkbox"/> DIFFICULTY SWALLOWING | <input type="checkbox"/> MOTION SICKNESS | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> FEVER/CHILLS/SWEATS | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> UNEXPLAINED WEIGHT LOSS | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> BLOOD CLOTS | <input type="checkbox"/> BLEEDING PROBLEMS |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> HIV/HEPATITIS |
| <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> HISTORY OF SMOKING | <input type="checkbox"/> HISTORY OF ALCOHOL ABUSE |
| <input type="checkbox"/> HISTORY OF DRUG ABUSE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> DEPRESSION/ANXIETY |
| <input type="checkbox"/> MYOFASCIAL PAIN | <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> PREGNANCY |
| <input type="checkbox"/> CANCER | | |



FALLS EFFICACY SCALE

On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you do the following activities without falling?

Activity	Score: 1 = very confident 10 = not confident at all
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 a chair	
Getting dressed and undressed	
Personal grooming (i.e. washing your face)	
Getting on and off the toilet	
TOTAL SCORE	



PAIN DISABILTY INDEX

The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst. For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/home responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (eg, yard work) and errands or favors for other family members (eg, driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 *Worst disability*

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 *Worst disability*

Social activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 *Worst disability*

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

No disability 0 1 2 3 4 5 6 7 8 9 10 *Worst disability*

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker

No disability 0 1 2 3 4 5 6 7 8 9 10 *Worst disability*

Sexual behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 *Worst disability*

Life-support activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 *Worst disability*