Pequa Physical & Aquatic Therapy
Your pain relieved. Your life restored.
2848 Middle Country Rd, Lake Grove NY 11776
913 North Broadway, Massapequa NY 11758

Worker's Compensation Patient Information

Case Information

Insurance Name:	Date of Injury:
Claims Address:	Body Part:
Carrier Case #:	Adjuster Name:
WCB Case #:	Adjuster Phone #:

Employer Information

Name of Employer:
Address:

Worker's Compensation Terms and Conditions

You may become responsible for the medical costs of treatment for your illness or condition with the provider **Pequa Physical Therapy** if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Provider's Name and Address: _____

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New Patient Intake Form:

Demographics

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

Date of Birth: _____ **Social Security #:**_____

Gender: Male Female Other **Marital Status:** Single Married Divorced Widowed

Address: _____ **Apt #**: _____

City: _____ **State:** _____ **Zip code:** _____

Contact Information

How Did You Hear About Us? Internet Friend/Family Referring Physician Other_____

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

Preferred phone number: Home or Cell

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone #: _____

Doctor Information

Primary Care Physician: _____ **PCP Phone #:** _____

Referring Physician: _____**Referring Phone #:**_____

Insurance Information

Primary Insurance: _____ **Member ID:** _____

Group#: _____ **Provider Line Phone #:**_____

Secondary Insurance: _____ **Member ID:** _____

Group#: _____ **Provider Line Phone #:**_____

Print Name: _____

Signature: _____ Date: _____

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Medical History

Past Surgical History

Surgery	Reason/Body Part	Year

Medication List

Medication Name	Dosage	Frequency Taken

Allergies

Please list anything that you are allergic to (medications, food, etc.) and how it affects you.

_____

_____

_____

Diagnostic Imaging

Have you received any diagnostic imaging for your current injury/condition? ❒ Yes ❒No

If yes, which body part and where was it done? (Specify which company and which town)

_____

Print Name: _____

Signature: _____ Date: _____

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Medical History

Are you under a physician's care now? ❒ YES ❒ NO
If Yes, Explain: _____

Have you ever been hospitalized or had a major operation? ❒ YES ❒ NO
If Yes, Explain: _____

Have you ever had a serious neck or head injury? ❒ YES ❒ NO
If Yes, Explain: _____

Are you on a special diet? ❒ YES ❒ NO
If Yes, Explain: _____

Do you use tobacco? ❒ YES ❒ NO If Yes, How Often: _____

Do you currently use recreational or street drugs? ❒ YES ❒ NO
If Yes, Explain: _____

Do you use controlled substances? ❒YES ❒ NO
If Yes, Explain: _____

Have you been on Cortisone Medicine for more than 6 weeks? ❒ YES ❒NO

Women: are you pregnant or nursing? ❒YES ❒ NO

Is this injury/condition related to work? ❒ YES ❒NO

Is this injury/ condition related to an Auto Accident? ❒ YES ❒ NO

Have You Had Physical Therapy before for this injury/condition? ❒ YES ❒ NO
If Yes, when and where: _____

How often do you exercise? ❒NEVER ❒ OCCASSIONALLY ❒ MODERATELY ❒ HIGH LEVEL

How often do you drink alcohol? ❒ Never ❒ Less than 3X/WK ❒ More than 3X/WK

Print Name: _____

Signature: _____ Date: _____

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Medical History

Please check ✓ if you have, or have you had any of the following

AIDS / HIV Positive		Hemophilia	
Alzheimer's Disease		Hernia	
Anemia		Herpes	
Any Pins or Medical Implants		Hepatitis A, B or C	
Arthritis/Rheumatoid Arthritis		High Cholesterol	
Artificial Joint		High Blood Pressure	
Asthma		Hives or Rash	
Blood Disease		Hypoglycemia	
Blood Transfusion		Irregular Heartbeat	
Blood Clot/Emboli		Kidney Problems	
Bowl or Bladder Problems		Leukemia	
Breathing Problems		Liver Disease	
Bruise Easily		Low Blood Pressure	
Cancer		Lung Disease	
Chemotherapy/Radiation		Numbness or Tingling	
Chest Pains/ Shortness of Breath		Multiple Sclerosis	
Cold Sores/Fever Blisters		Osteoporosis/Osteopenia	
Congenital Heart Disorder		Pain In Jaw	
Do You Smoke?		Psychiatric Care	
Diabetes		Renal Dialysis	
Drug Addiction		Shingles	
Emphysema		Sickle Cell Disease	
Epilepsy or Seizures		Sinus Trouble	
Excessive Bleeding		Sleeping Problems	
Fainting/Dizziness		Stomach/Intestinal Disease	
Fibromyalgia		Spina Bifida	
Frequent Cough		Spinal Cord Injury	
Frequent Diarrhea		Stroke	
Genital Herpes		Swelling Of Limbs	
Glaucoma		Thyroid Disease	
Gout		Tuberculosis	
Heart Attack/Failure		Tumors Of Growths	
Heart Murmur		Ulcers	
Heart Pacemaker		Vision or Hearing Difficulties	
Heart Trouble/ Disease		Venereal Disease	

Print Name: _____

Signature: _____ Date: _____

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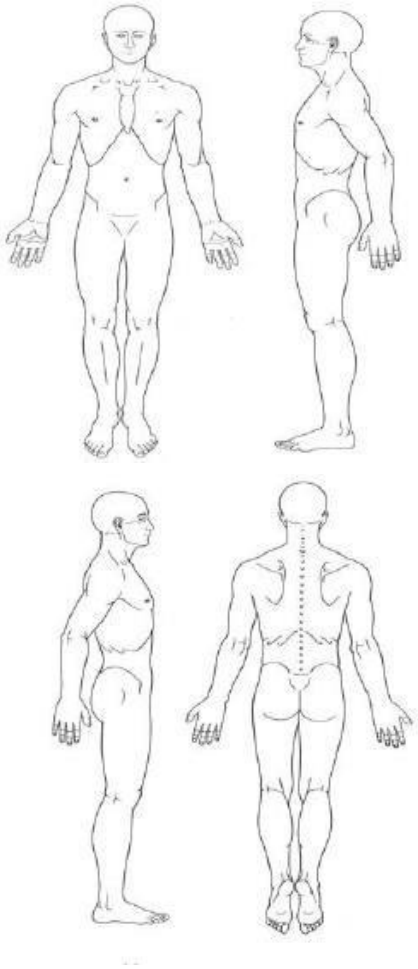
Pain Assessment

Please Indicate Where You Have Pain or Other Symptoms



Please identify on a scale of 0-10 (0 being no pain, 10 being unbearable pain)

PRESENT: _____/10 AT BEST: _____/10 AT WORST: _____/10

1. Describe your symptoms: _____

_____

_____

_____

_____

2. How Did Injury Occur: _____

_____

_____

_____

_____

3. When Did Injury Occur: _____

_____

_____

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)

What describes the nature of your symptoms?

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

Are you aware of your diagnosis (what you are being treated for at our clinic)? ❒ Yes ❒ No

Print Name: _____

Signature: _____ Date: _____

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Aqua Therapy Screen

Please Check ✓ The Box Below If You Have Any Of The Following:

❒ Typhoid, Cholera, Dysentery, Or Any Other Waterborne Disease

❒ Fever Higher than 100° F

❒ Kidney Disease

❒ Stomach of Intestinal Disorder

❒ Infectious Disease

❒ Open Wounds

❒ Skin Rashes

❒ Perforated Ear Drums

❒ Incontinence

❒ Difficulty Breathing

❒ Epilepsy

❒ Radiation Treatment within the last 3 months

❒ High Blood Pressure

❒ Heart Disease

❒ Pacemaker or Defibrillator

Print Name: _____

Signature: _____ Date: _____