next step

Next Step Physical Therapy, PLLC
131 Old Country Road, Suite B
Hicksville, New York 11801
Phone 516.681.8070
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PATIENT INFORMATION

Patient # _____ Date _____

Name _____ Sex: Male Female Age _____

Address _____ City _____ Zip code _____

Home Phone # _____ Social Security # _____ Birth Date _____

Employer _____ Daytime Phone #_____

Type of Work _____

Marital Status: (circle one) Married Single Divorced Separated Widowed

Emergency Contact Person: Name and relationship to you _____

_____Phone # _____

Physician that referred you to physical therapy _____

Who told you about Next Step Physical Therapy (if anyone other than your physician)

_____

Health Insurance Carrier (if any) _____Policy Holder _____

Insurance card ID # _____

I understand that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Next Step Physical Therapy, PLLC will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to Next Step Physical Therapy, PLLC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. In the event of non-payment, I am legally responsible for any collection fees involved in satisfying my debt. I also authorize Next Step Physical Therapy to evaluate and treat me as deemed appropriate by a Next Step physical therapist.

Signature of Patient or Guardian _____ Date _____
Witness _____ Date _____

CLIENT CHECKLIST

NAME: _____ **DATE:** _____

REASON FOR SEEKING PHYSICAL THERAPY:

HAVE YOU HAD A COMPLETE MEDICAL CHECK-Ul:' WITIDN THE LAST YEAR?

DO YOU NOW HAVE OR HAVE YOU RECENTLY HAD ANY.OF THE FOLLOWING COMPLAINTS

_____ **Shortness of breath**
_____ **Dizziness**
_____ **Pain or a feeling of heaviness in your chest**
_____ **Pulsating pain anywhere in your body**
_____ **Constant and severe pain in lower leg (calf)**
_____ **Discolored or painful feet**
_____ **Dizziness**
_____ **Swelling**

_____ **Persistent pain at night**
_____ **Constant pain anywhere in your body**
_____ **Unexplained weight loss/10-15 lbs. in 2 weeks**
_____ **Loss of appetite**
_____ **Unusual lumps or growths**
_____ **Fatigue**

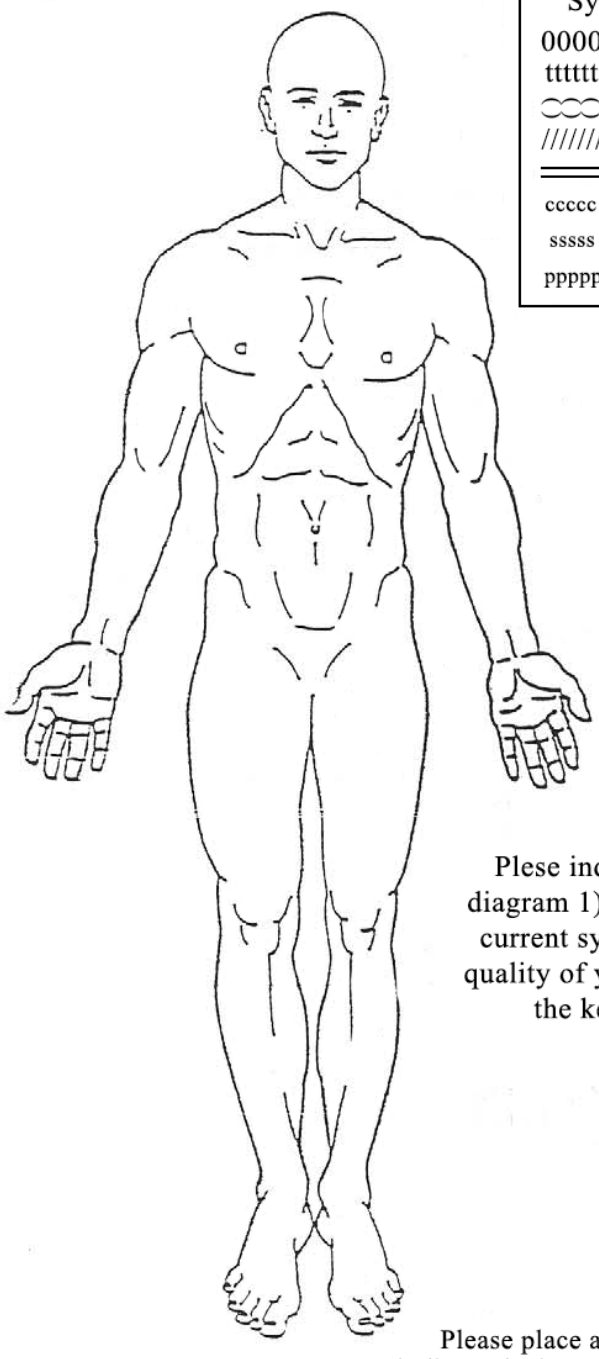
_____ **Frequent or severe abdominal pain**
_____ **Frequent heartburn or indigestion**
_____ **Frequent nausea or vomiting**
_____ **Change or problems with bladder function (i.e., urinary tract infection)**
_____ **Change or problems with bowel function**
_____ **Unusual menstrual irregularities**

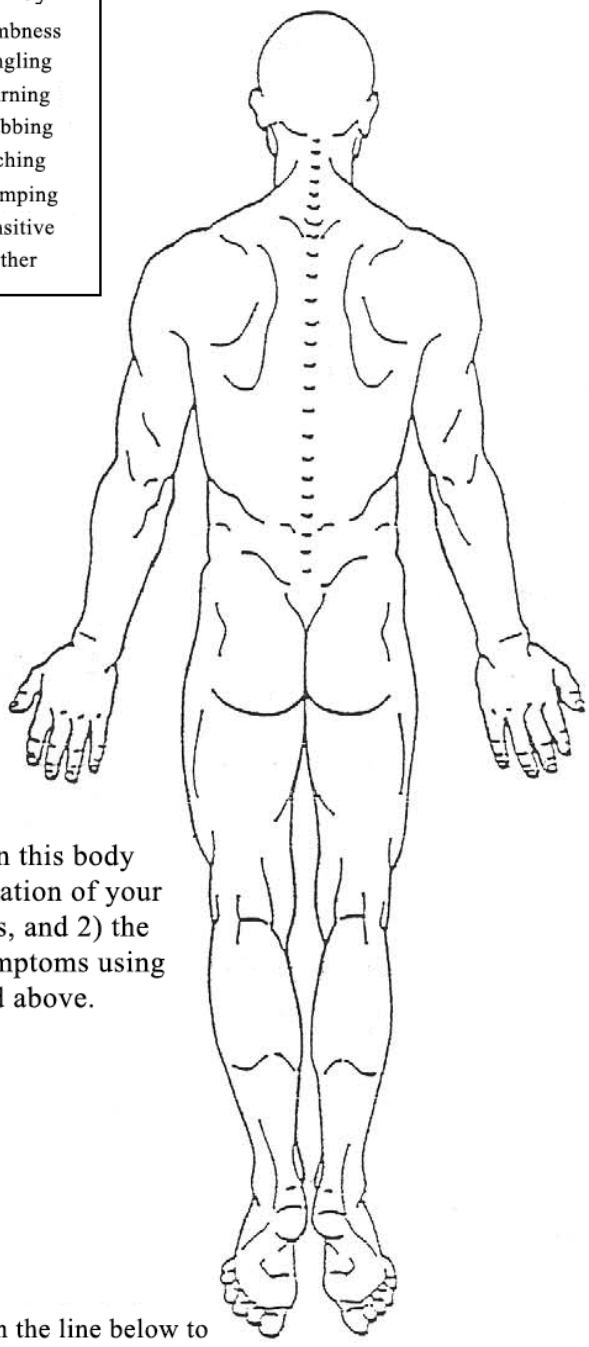
_____ **Changes in bearing**
_____ **Frequent or severe headaches**
_____ **Problems with swallowing or changes in speech**
_____ **Changes in vision (i.e., blurred vision or loss of sight)**
_____ **Problems with balance or falling**
_____ **Fainting spells**
_____ **Problems with coordination**
_____ **Sudden weakness**

_____ **Fever/night sweats**
_____ **Recent severe emotional disturbances**
_____ **Swelling or redness in any joints**
_____ **Pregnant**

WHOLE BODY SYMPTOMS DESCRIPTION

Symptom Key	
0000	Numbness
ttttt	Tingling
⌒⌒⌒	Burning
///////	Stabbing
═══	Aching
ccccc	Cramping
sssss	Sensitive
ppppp	Other





Plese indicate on this body diagram 1) the location of your current symptoms, and 2) the quality of your sumptoms using the key listed above.

Please place an "X" on the line below to indicate the intensity of your current symptoms.

no pain — worst possible

Medical Intake Form

Current Medications

Medication	Reason for medication

List any other medical conditions you have that you are not taking medication for:

Please list all surgeries

surgery	year of surgery

Do you have any other medical history not already mentioned (for example - cancer, depression, heart disease, broken bones, etc).