2140 Bellmore Ave
Bellmore, NY 11710
(516) 586-5533
Fax 516-586-5531

Sid Jacobson JCC
300 Forest Drive
East Hills, NY 11548
(516) 626-8787
Fax: 516-626-8789
POOL

Sherrie Glasser MS PT, Owner/Director

333 East Shore Rd
Manhasset, NY
11030
(516) 466-9730
Fax: 516-466-1228

800 East Gate Blvd
Garden City, NY 11530
(516) 745-8050
Fax: 516-745-6766
POOL

745 Route 25A
Rocky Point, NY 11778
(631) 849-6000
Fax (631) 849-6002
POOL

HISTORY OF INJURY QUESTIONAIRE

INITIAL **LOWER EXTREMITY/BACK** HISTORY

Name:____Date of Birth:___/___/____Today's Date:___/___/____

Home phone #:___________ Cellular #:__________ Work phone #:__________ Best # to call? Work / Home / Cell

Are you working? Yes No. If no, do you have a job to return to? Yes No. What is your occupation?_______________

Injured Joint:_____________________________________ Right___ Left___ Date of Injury: __________________

Briefly describe the history of your injury/symptoms:____

____

____

____

What are your symptoms? Pain/Swelling/Stiffness/Weakness/Instability/Clicking/Other:________________________

Does the pain wake you at night? Yes___ No____ No Pain___

Please Indicate with an "R" and/or "L":

Pain at rest: None________________________Severe
0 1 2 3 4 5 6 7 8 9 10

Pain w/ activities: None________________________Severe
0 1 2 3 4 5 6 7 8 9 10

Circle the most applicable answer:

Swelling at its worse: None/ Mild/ Moderate/ Severe

Do you experience giving way? None/ Sensation of Giving Way/ Actual Giving Way

Do you experience Locking? None/ Sensation of Locking/ Actual Locking

Difficulty Ascending stairs? None/ With Difficulty/ Unable Descending stairs? None/ With Difficulty/ Unable

What makes your symptoms worse?____

What makes your symptoms better?____

What sports/activities do you participate in?____

What activities are you unable to participate in?____

What would you like to do? What are your goals?____

What MD's have you seen for this injury/problem?____

What was the diagnosis and treatment given?____

Have you ever had an x-ray or MRI of this joint? Yes_____ No____ If yes, when and what was the result? (please supply us with the report)____

Any previous surgery for this injury? Yes____ No_____ If yes, what surgery did you have?______________________

____When?______________________________________

Who was your surgeon?_______________________________What hospital?__________________________________

Please provide address and phone # of the surgeon:____

List all previous other operations including dates:____

Do you have a history of:

___Fainting spells ___Heart Disease ___Cancer ___Seizures ___Diabetes

___Stroke ___Pacemaker ___Circulatory Condition

___Other (explain)____

Answer with a Y (yes) or N (no)

___ Are you thirsty often? ___Do you have shortness of breath? ___Pain or tightness in chest?

___High or low blood pressure ___High or low blood sugar? ___Kidney or liver deisease?

___Hepatitis ___Bruise easily

List all medications you are taking:____

Please list any allergies:____

Who is your family physician?

Name:__________________________________

Address:________________________________

____

Phone #:________________________________

May we send office notes? Yes_____ No____

How did you learn about Metropolitan Physical Therapy?

Doctor/Former Patient/Friend/Internet/Yellow Pages/Other

Name:____

Address:____

____

Phone #:____

PATIENT RESPONSIBILITIES

Metropolitan Physical Therapy will bill your insurance carrier at our contracted rates. You will be responsible for meeting your co-payments, deductibles or co-insurances after each visit, and please be aware of your insurance policy provisions. If we get denied payment for any reason due to provisions, you will be responsible to pay us for the denied visits. If you have any questions please ask our billing department or contact your insurance directly. Once your insurance benefits are exhausted, if you wish to continue treatment, you will be responsible for our private fee. There will be an increase of fee if more than one diagnosis is being treated, additional equipment or multiple procedures are used; e.g. Cybex, Nautilus, Eagle. If this account shall be placed in the hands of an outside attorney for collection, the Responsible Party agrees to pay all costs of collection, including reasonable attorney's fees, not to exceed 20% of the unpaid balance, together with necessary court costs and disbursements. There will be a $60 cancellation fee for appointments that are not cancelled 24 hours in advance. We also ask that if you are going to be late to your appointment, please call to notify us. We are trying our best to accommodate you and your schedule and in order to so we suggest that you book your appointments 4-6 weeks in advance so that you can get the time that you want.

The condition being treated **IS** or **IS NOT** the result of a work or on the job accident or motor vehicle accident. If it **IS** please circle one: Work/ On The Job Motor Vehicle Accident

I have read the above and agree to the Terms and Conditions. If under 18 please have a parent/guardian sign.

Signature: ____ *Date:* __________________________