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## HISTORY OF INJURY QUESTIONNAIRE INITIAL UPPER EXTREMITY/NECK 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: \_\_\_\_\_

Dominant Hand: Right \_\_\_ Left \_\_\_ Briefly describe the history of your injury/symptoms: \_\_\_\_\_

What are your symptoms? Pain/Swelling/Stiffness/Weakness/Instability/Numbing/Other: \_\_\_\_\_

Where specifically are your symptoms? \_\_\_\_\_

Does the pain wake you at night? Yes \_\_\_ No \_\_\_ No Pain \_\_\_

Has your shoulder ever dislocated? Yes \_\_\_ No \_\_\_ # of times \_\_\_

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

Pain at rest: None \_\_\_\_\_ Severe Pain w/ activities: None \_\_\_\_\_ Severe  
0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

Please circle any limitation in range of motion: RIGHT: None / Mild / Moderate / Severe

LEFT: None / Mild / Moderate / Severe

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 disease?  
\_\_\_ Hepatitis      \_\_\_ Bruise easily

List all medications you are taking: \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Who is your family physician?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

How did you learn about Metropolitan Physical Therapy?

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

May we send office notes? Yes \_\_\_ No \_\_\_

### 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: \_\_\_\_\_