Island Bodyworks
Physical Therapy

Current Condition

When did the injury or illness start? __ __ / __ __ / __ __ __ __
Month Day Year

What was the **cause** of your current condition: _____

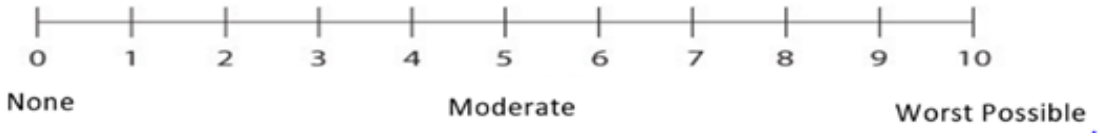
_____

Please **describe** your current symptoms: _____

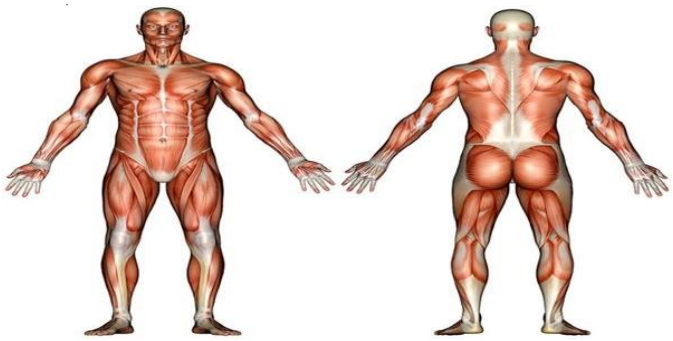
_____

According to the scale below, rate the level of your symptoms.

Worst: _____
Current: _____
Best: _____



Please mark where you are experiencing your symptoms:



Better With: (check all that apply)

- ☐ Sitting
- ☐ Bending Forward
- ☐ Sit to Stand
- ☐ Lying on Side
- ☐ Morning
- ☐ Rest
- ☐ Stairs
- ☐ Pain Medicine
- ☐ Standing
- ☐ Bending Backward
- ☐ Walking
- ☐ Lying Flat
- ☐ Evening
- ☐ Movement
- ☐ Stretching
- ☐ Heat/Ice

Worse With: (check all that apply)

- ☐ Sitting
- ☐ Bending Forward
- ☐ Sit to Stand
- ☐ Lying on Side
- ☐ Morning
- ☐ Rest
- ☐ Stairs
- ☐ Pain Medicine
- ☐ Standing
- ☐ Bending Backward
- ☐ Walking
- ☐ Lying Flat
- ☐ Evening
- ☐ Movement
- ☐ Stretching
- ☐ Heat/Ice

Please list any other activities or movements that you are limited with: _____

_____

What do you want to work on in Physical Therapy and what goals do you have: _____

_____

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Patient Information

Name: _____ Date of Birth: _____ Age: _____

Referring Physician (If Any): _____

Next appointment with Referring Physician: _____

Emergency Contact/Phone Number: _____

Medical History

Have you experienced this condition in the past? ☐ Yes ☐ No If Yes, When? _____

Are you receiving or have you received any other treatments for your current condition? Home PT/OT, Outpatient PT/OT, Chiropractic, Massage, Injections, Other _____

If Yes, what type and when? _____

Have you had any related surgeries? ☐ Yes ☐ No

If Yes, what type and when? _____

Please check if you currently have or ever had any of the following:

☐ Arthritis	☐ Osteoporosis	☐ Broken Bones/ Fractures	☐ Skin Diseases
☐ High Blood Sugar	☐ Low Blood Sugar	☐ Diabetes	☐ Infectious Disease
☐ Seizures	☐ Epilepsy	☐ Depression	☐ Thyroid Problems
☐ High Blood Pressure	☐ Stroke	☐ Circulation	☐ Kidney Problems
☐ Parkinson's Disease	☐ Muscular Dystrophy	☐ Multiple Sclerosis	☐ Blood Disorders
☐ Head Injury	☐ Allergies	☐ Ulcers/Stomach Problems	☐ Lung Problems
☐ Cancer	☐ Heart Problems	☐ Pacemaker/Defibrillator	☐ Asthma

Please describe any of the above checked boxes: (types, dates, etc.)

_____

_____

Medication List: (Please include over the counter medications and/or supplements. You may provide a list for our office to copy.)

Drug	Dosage	How often	Reason

☐ Check here if you gave a separate list of medication

**Please inform your therapist of any medication changes that may occur throughout the course of your treatment.

_____ _____

Signature Date

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Patient Authorization for use and disclosure of protected health information statement of privacy notice

We may disclose your health care information:

1. To other health care professionals within our practice for the purpose of treatment, payment or health care operations.
2. To your insurance provider(s) for the purpose of payment or health care operations.
3. To comply with State Worker's Compensation laws
4. To public health employees for preventing/controlling disease and reporting infectious exposures.
5. In the course of any administrative or judicial proceeding or law enforcement purposes.

Under HIPAA federal privacy law, you have the right to:

1. Request restrictions on certain uses and disclosures of your health information.
2. Inspect and copy your health care information
3. Receive an accounting or disclosures of your protected health information made by us.
4. Obtain a paper copy of this Notice of Privacy Practice at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future.
We are required by law to maintain the privacy of your health information.

If you have any questions regarding this notice or if you want more information about your privacy rights, please contact us at (716) 773-3300.

My signature indicates my authorization and consent for Island BodyWorks Physical Therapy to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described above.

_____

Patient's Signature

_____ Date:_____

Patient's Name (Print)

Island Bodyworks
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CANCELLATION POLICY

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation:
When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. To be respectful of your fellow patients, please call our office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment:
If you need to cancel your appointment, please call us at (716) 773-3300. Please leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows:
A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a **$40 missed appointment fee.** This fee can be avoided if the patient reschedules within a 24-hour period from their original appointment time.

If a patient no-show for 2 appointments or cancels 3 appointments, you may be discharged from our care and a case update will be sent to the referring doctor.

I have been informed of this cancellation policy and agree to its terms and conditions.

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____ **DATE:** _____