# Momentum Physical Therapy of New Paltz, PLLC

246 Main Street
Ignite Fitness, 2nd Floor
New Paltz, NY 12561
(845) 419.1432
momentumptnp@gmail.com

## Client Information

Date:_____

First Name:_____ Last Name:_____

Address:_____ DOB:_____

_____ Age:_____

Preferred Phone #:_____ (H/C) Email:_____

Employer/Occupation:_____

Referral to Momentum PT: Family Friend Doctor Internet Event/Workshop Other

Referring Physician:_____ Phone #:_____

Emergency Contact:_____ Phone #:_____

## Medical History

Height:_____ Weight:_____ Hand Dominance (please circle): Right Left

Did you have surgery?: Y/N If yes, please list the procedure, date of surgery, and surgeon:

_____

When did your symptoms start?:_____

How did your symptoms start?:_____

_____

_____

What is your main complaint?:_____

_____

Are your symptoms changing?: Getting Better No Change Getting Worse

What activities/positions ***aggravate*** your symptoms?: (i.e. Sitting, Walking, Stair Climbing)

_____

What activities/positions ***relieve*** your symptoms?: (i.e. Heat/Ice, Walking, Exercise)

_____

How often do you experience your symptoms during the day? (please circle):

Constant (**76-100%**) Frequently (**51-75%**) Occasionally (**26-50%**) Intermittently (**0-25%**)

When are your symptoms ***worst***?

____ Morning
____ Afternoon/Evening
____ Night
____ No Difference

When are your symptoms ***best***?

____ Morning
____ Afternoon/Evening
____ Night
____ No Difference

Have you received any diagnostic test(s)?: X-ray MRI CT Scan Ultrasound Other

Are you on any work restrictions from your physician?: Y/N If yes, please describe:_____

_____

What are your leisure, recreational and/or exercise activities?:_____

_____

What are your goals?:

1. _____ 2. _____

3. _____ 4. _____

Have you sought care elsewhere?: Y/N If yes, please describe:_____

_____

Please list any medications you are currently taking:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list any previous surgeries including the procedure, date and surgeon:

1. _____

2. _____

3. _____

4. _____

Please list any other past medical history that you think may be relevant:

_____

_____

Please list any allergies:_____

Do you have a sensitivity/allergy to latex?: Y / N

Do you smoke?: Y / N

Do you have a pacemaker?: Y / N

Are you pregnant or think you may be pregnant?: Y / N N/A

Have you recently experienced any of the following? (please circle):

| | | |
|---|---|---|
| Fevers/Chills/Sweats | Falls | Shortness of Breath |
| Fatigue | Balance Difficulties | Cough |
| Dizziness/Lightheadedness | Muscle Weakness | Difficulty Swallowing |
| Headaches | Numbness/Tingling | Change in Bowel/Bladder |
| Fainting | Unexplained Weight Gain/Loss | Diarrhea |
| Nausea/Vomiting | Heartburn/Indigestion | Constipation |

Have you ever been diagnosed with any of the following? (please circle):

| | | |
|---|---|---|
| Sensitivity to Heat/Cold | Osteoarthritis | Seizures |
| Asthma | Rheumatoid Arthritis | Vision Impairment |
| Anemia | Gout | Hearing Impairment |
| Heart Disorder | Osteoporosis/penia | Ulcers |
| Pulmonary Disorder | Thyroid Disorder | Liver Disease |
| High Blood Pressure | Multiple Sclerosis | Kidney Disease |
| Circulation Disorder | Cancer | Bladder/Urinary Infection |
| Blood Clots | Depression | Tuberculosis |
| Stroke/CVA | Autoimmune Disorder | Hepatitis |
| Diabetes (I or II) | Chemical Dependency | STD/HIV |

Other:_____

## Conditions and Consent for Physical Therapy

I hereby consent to evaluation and treatment performed by a licensed physical therapist.

Initial:_____

I acknowledge that I have been given the opportunity to review a copy of the Notice of Privacy Practices, which can be downloaded at: www.momentumptnp.com/forms.

Initial:_____

Momentum Physical Therapy of New Paltz, PLLC, and Ignite Fitness and its staff members are not responsible for loss or damage to personal valuables.

Initial:_____

I confirm that I have read, fully understand and agree to all of the above information.

Client Name (print):_____

Signature:_____ Date:_____

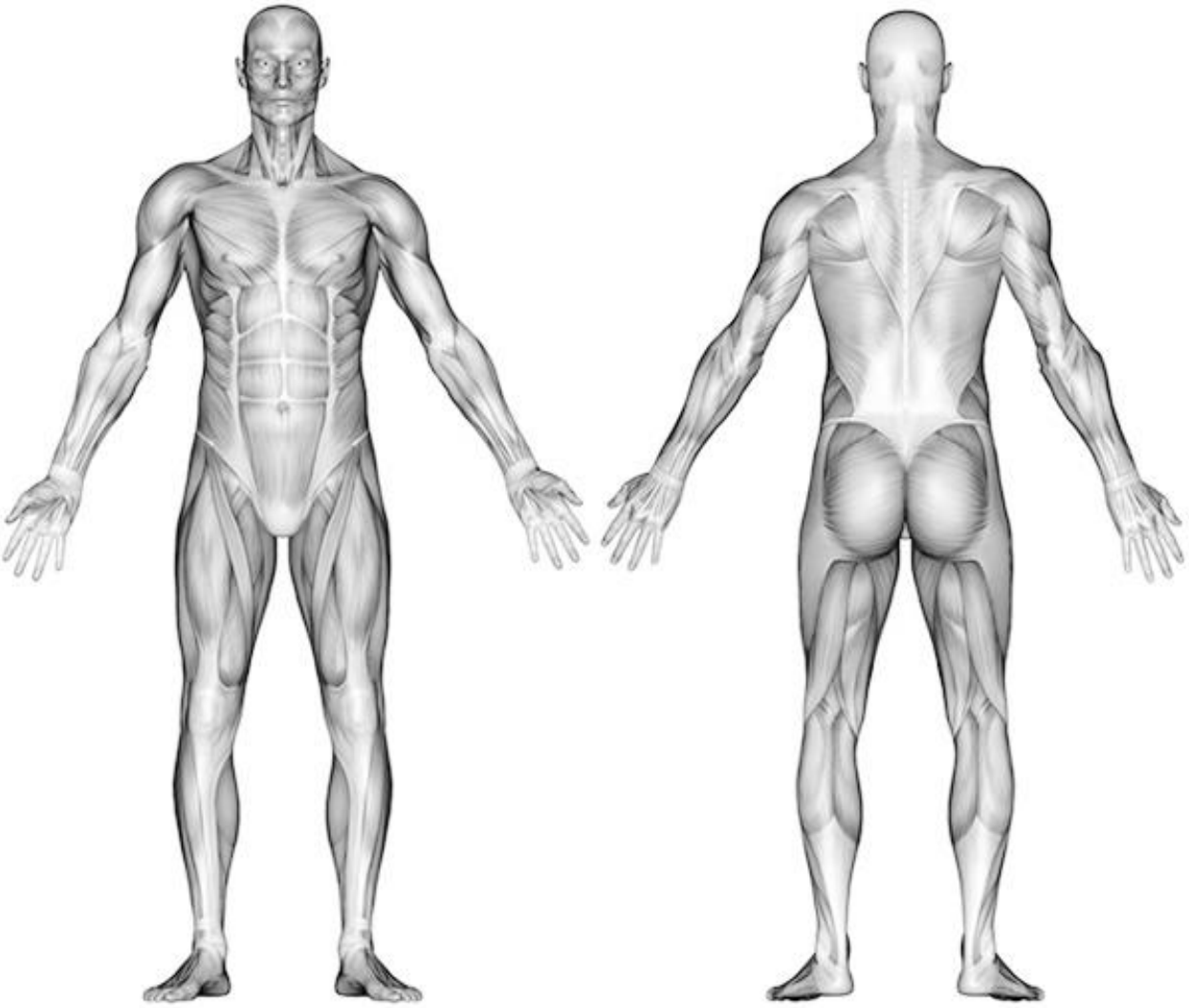
Signature:_____ Date:_____

(Parent/Guardian if client is under 18 years of age)

## Pain Questionnaire

Please indicate the location and nature of symptom(s) you have experienced over the last 24-48 hours on the image below using the following key:

Ache: **XXXXX** Sharp/Stabbing: **/////** Burning: **ZZZZZ** Numbness/Tingling: **OOOOO**



Please rate your ***current*** level of pain/symptoms on the following scale:

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Please rate your ***worst*** level of pain/symptoms over the last 24-48 hours on the following scale:

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Please rate your ***best*** level of pain/symptoms over the last 24-48 hours on the following scale:

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

## Cancellation/No Show Policy

Physical therapy appointments represent a time specifically set aside for you as a patient. It is understood that unforeseen circumstances can lead to late, missed or cancelled appointments. In the event that you know you are unable to keep a scheduled appointment, please notify us at least 24 hours in advance to avoid incurring fees. We reserve the right to charge for missed appointments, (no show or late cancel), in the amount of **$130** for each occurrence which will be billed to the credit card on file.

## Credit Card Authorization - *All information will remain confidential.*

I agree with the outlined cancellation policy above and authorize Momentum Physical Therapy of New Paltz, PLLC to charge for fees associated with missed appointments, (no show or late cancel).

Cardholder Signature:_____ Date:_____

Name On Credit Card:_____

Billing Address (if different than above):_____

_____

Credit Card Type: [ ] Visa [ ] MC [ ] AmEx [ ] Discover

Credit Card Number:_____

Exp. Date:_____ CVV Code:_____

## Communications Policy

**Contacting Momentum Physical Therapy of New Paltz:**

When contacting Greg for any reason, the most effective ways to get in touch are:

- Phone/Voicemail: 845-419-1432. This is confidential.
- Text message: 845-419-1432 or email: momentumptnp@gmail.com. Please review and complete the *Consent for Non-Secure Communications* policy below.
- If you need to send a file such as a PDF or other digital document, please send it to momentumptnp@gmail.com.

Response Time:

- Greg may not be able to respond to your calls and messages immediately but you can expect a response within 1 business day. On weekends, it is possible that Greg can respond more quickly but that may not always be the case.

**Disclosure Regarding Third-Party Access to Communications:**

- Please know that if electronic communication methods are utilized like email, texting, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others.
- Technical experts often describe email as being like a postcard, in that it can be viewed by all hands it passes through.
- Think about where you read and write emails, and what devices you do that on. Of special consideration are work email addresses. If you use your work email to communicate with Greg, your employer may legally access your email communications. There may be similar issues involved with school email or other email accounts associated with organizations that you are affiliated with.
- Additionally, people with access to your computer, mobile phone and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access your accounts.

## Consent for Transmission of Protected Health Information by Non-Secure Means

I, _____, authorize Momentum Physical Therapy of
(print patient name or parent/guardian)

New Paltz, PLLC to transmit protected health information related to my, or my child's, health records and health care treatment by email and text messaging.

This may include items such as:

- Scheduling appointments or meetings
- Billing and payment related information such as receipts/invoices
- Home exercise/self treatment recommendations

I have been informed of the risks of transmitting my protected health information through unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

Signature:_____ Date:_____

**OR**

I, _____, authorize Momentum Physical Therapy of
(print patient name or parent/guardian)

New Paltz, PLLC to use email to deliver home exercise/self treatment recommendations only.

Signature:_____ Date:_____