

KIPNIS PHYSICAL THERAPY AND SPORTS MEDICINE

PATIENT INFORMATION AND AUTHORIZATION FORM

Kipnis Acct. # _____
Office: CP Sec Hack

PLEASE PRINT LEGIBLY

Social Security No. _____ Today's Date _____

First Name _____ Last Name _____

Marital Status: (Circle One) Married Single Divorced Spouse's Name _____

Birth Date _____ Age _____ Sex: (Circle One) Male Female

Home Address _____

City/State/Zip _____ Home Phone _____

Work Phone _____ Cell Phone: _____ E-mail _____

Employer Name _____

Work Address _____

Current Work Status: (Circle One) Full Time Part Time Retired Unemployed On Disability Restricted Work

Student Homemaker Not Working Due to Injury Occupation _____

Is this condition due to: ___ Auto Accident ___ Workers Comp Injury ___ Slip and Fall ___ Other

If you currently have an attorney working with you, please provide his/her name.

Have you ever received physical therapy for this condition while under your current insurance plan? Yes No

Have you received physical therapy this calendar year? Yes No If yes, please state where and when.

CIRCLE THE CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST

High Blood Pressure Angina Heart Attack Stroke Asthma HIV/Aids Diabetes Broken Bones

Back/Neck Injuries Arthritis Herniated Disc Lupus Sciatica Surgery Cancer Pacemaker

Cigarette Smoker Tumor Other _____

Medications _____

Is there a possibility you are pregnant? Yes No (Circle One)

Please state the body parts where your problems or injuries are located, and give a brief description of your current complaints _____

Please give a date (actual or approximate) this problem started. _____

Please describe how your condition or injury started. _____

Have you ever been treated for this condition before? Yes No

Date and location where you were last treated. _____

Are you currently being seen by a chiropractor for the same condition? Yes No

When is your next appointment with the doctor who is seeing you for this condition? _____

KIPNIS PHYSICAL THERAPY AND SPORTS MEDICINE
MDHAQ- Initial Evaluation

Name: _____ Date: _____ Account #: _____

Please answer each question exactly how you feel today.

1. Please check (✓) the ONE best answer for your abilities at this time:

OVER THE WEEK , were you able to:	Without ANY Difficulty	With SOME difficulty	With MUCH difficulty	Unable to do
a. Dress yourself, including tying shoelaces and doing buttons?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. Get in and out of bed?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. Lift a full cup or glass to your mouth?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. Walk outdoors on flat ground?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. Wash and dry your entire body?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. Bend down to pick up clothes from the floor?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g. Turn regular faucets on and off?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
h. Get in and out of a car, bus, train or airplane?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
i. Walk two miles?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
j. Participate in recreational activities/sports as you would like?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
k. Get a good night's sleep?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
l. Deal with feelings of anxiety or being nervous?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
m. Deal with feelings of depression or feeling blue?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

2. How much pain have you had because of your condition over the past week? Please indicate below:

NO PAIN ○ **WORST PAIN**
 0 .5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. When you awoken in the morning OVER THE PAST WEEK, did you feel stiff?

No Yes If "Yes", for how long? Please write duration: minutes: _____, or hours _____

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL ○ **VERY POORLY**
 0 .5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

For office use only: 1. a-j FN: (0-10)

1=.03 2=.03 3=1.0 4=1.3 5=1.7 6=2.0 7=2.3 8=2.7 9=3.0 10=3.3 11=3.7 12=4.0 13=4.3 14=4.7 15=5.0
 16=5.3 17=5.7 18=6.0 19=6.3 20=6.7 21=7.0 22=7.3 23=7.7 24=8.0 25=8.3 26=8.7 27=9.0 28=9.3 29=9.7 30=10

1. FN (0-10) 2. PN (0-10) 4. PTGL (0-10) **RAPID 3 (0-30)**

4a. How much of a problem has UNUSUAL fatigue or tiredness been for you over the past week? Please indicate below:

FATIGUE: NO PROBLEM ○ **FATIGUE: MAJOR PROBLEM**
 0 .5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

4b. How do you feel TODAY compared to one week ago? Please check (✓) one only.

Much Better 1 Better 2 The Same 3 Worse 4 Much Worse 5

4c. At this time, are you? Please check (✓) all that apply:

Working Fulltime Retired Working part time Student Homemaker-full time Disabled

Other: please describe: _____ Your occupation: _____

Name: _____ Date: _____ Account #: _____

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FOR OFFICE USE ONLY: 5.ROS

5. Please check (✓) if you have experienced any of the following over the last month:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Lump in your throat | <input type="checkbox"/> Paralysis of arms or legs |
| <input type="checkbox"/> Weight gain(>10lbs) | <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness or tingling of arms or legs |
| <input type="checkbox"/> Weight loss(<10lbs) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Feeling sickly | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in the chest | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Unusual Fatigue | <input type="checkbox"/> Heart Pounding(Palpations) | <input type="checkbox"/> Swelling in other joints |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Heartburn or stomach gas | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Skin rash or hives | <input type="checkbox"/> Stomach pain or cramps | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Unusual bruising or bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Use of drugs not sold in stores |
| <input type="checkbox"/> Other skin problems | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Smoking cigarettes |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Constipation | <input type="checkbox"/> More than 2 alcoholic drinks/day |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression- feeling blue |
| <input type="checkbox"/> Other eye problems | <input type="checkbox"/> Dark or bloody stools | <input type="checkbox"/> Anxiety- feeling nervous |
| <input type="checkbox"/> Problems with hearing | <input type="checkbox"/> Problems with urination | <input type="checkbox"/> Problems with thinking |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Gynecological problems | <input type="checkbox"/> Problems with memory |
| <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Problems with Sleeping |
| <input type="checkbox"/> Sores in the mouth | <input type="checkbox"/> Losing your balance | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Muscle pain,aches or cramps | <input type="checkbox"/> Burning in sex organs |
| <input type="checkbox"/> Problems with smell or taste | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Problems with social activities |

6. How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) for at least 30 minutes? Please check on only one:

- | | | |
|---|--|--|
| <input type="checkbox"/> 3 or more times per week | <input type="checkbox"/> 1-2 times per month | |
| <input type="checkbox"/> 1-2 times per week | <input type="checkbox"/> Do not exercise regularly | <input type="checkbox"/> Cannot exercise due to disability |

THANK YOU SO MUCH FOR COMPLETING THIS FORM FOR US!
The Staff of Kipnis Physical Therapy

KIPNIS PHYSICAL THERAPY AND SPORTS MEDICINE

Cliffside Park, NJ * Secaucus, NJ * Hackensack, NJ

PATIENT AUTHORIZATION AND INFORMATION FORM

Patient Name: _____ Acct# _____ Date of First Visit _____

1. To get full benefit from treatment, **you should attend as your therapist or doctor prescribed**. Therefore, if you cancel an appointment, you need to reschedule that appointment for therapy to occur the same week. If you have any **problems between treatments, PLEASE CALL OUR OFFICE IMMEDIATELY!** If your Kipnis PT doctor or therapist is not available, we will connect you with one of our other health care providers on staff.
2. Lockers and locks are available for your use, and we strongly recommend that you put your personal belongings in them at each and every visit. **Kipnis is not responsible for any items that are lost, stolen or damaged in any way.**
3. **Co-payments need to be paid at each and every visit unless** advance payment is made. Nonpayment may result in a **\$15 charge to your account**, which will not be covered by your insurance.
Thank you in advance for your cooperation, and we appreciate your helping us to contain administrative costs.
4. We require **24-hour notice for any appointment not attended**, otherwise a **\$25 charge maybe applied to your account**, which will not be covered by your insurance. (This does not apply in the event of poor weather conditions, emergency situations.) We reserve the right to waive this charge in certain circumstances.
5. To cover bank fees, there will be a **\$35.00 charge** for any checks returned or for any credit card charges that are not honored.
6. **We understand the difficulties that arise for some of our patients in covering health costs. If you have a financial difficulty or need some alternate payment arrangements made, please do ask us about those options for you. We will work with you to find a plan that will fit your budget.**

I understand that I am fully responsible for notifying Kipnis Physical Therapy and Sports Medicine of any changes regarding my medical coverage during ongoing treatment. The changes in medical coverage may include an auto accident, a work related injury, termination of insurance, a change of insurance company and /or policies. If I do NOT comply with this policy I understand, I will be liable for any and all outstanding bills.

I further understand that I am responsible for paying the balance of charges in the event my insurance does not fully cover my therapy costs, including whatever deductible, co-pay or percentage authorized or limited by law.

I hereby authorize and assign insurance benefits to Kipnis Physical therapy and the release of medical records as requested by my insurance company so that my bills can be processed.

I fully understand and will adhere to the above policies.

Patient Signature (Parent Signature if under 18)

Date

Acknowledgement of Notice of Privacy Practices

I certify that I have been offered a copy of the Notice of Privacy Practices from Kipnis Physical Therapy and Sports Medicine.

Patient Signature

Date

A staff member of Kipnis Physical Therapy and Sports Medicine certifies that the patient has been offered our current Notice of Privacy Practices.

Staff Member Signature (In the event the patient cannot sign) Date _____