Duffy & Bracken
WELLNESS & FITNESS • PHYSICAL THERAPY, P.C.

Dear Patient,

Welcome to Duffy & Bracken Physical Therapy. I am thrilled that you have chosen our practice.

Our mission is to have patients who are no longer suffering from their initial complaint, whose health has greatly improved, and who know they have been helped.

We have an excellent and experienced staff that loves to help people get better and will do their best to accomplish **your** goal.

I would like to give you an overview of the therapeutic process to expect:

- ❐ Each patient's treatment is individually designed.
- ❐ The treatment plan starts with techniques to control pain. This may include home treatment techniques, such as ice, heat, self-massage or self-mobilization.
- ❐ The next goal is to increase the movement and strength, which will be easier when you are in less pain and which will help to continue to decrease pain.
- ❐ Prevention of reoccurrence and return to your daily activities and sports is the final phase.

You can best help us meet your goals by attending all of your prescribed appointments, arriving on time and doing your prescribed home exercise program. Please schedule all of your appointments (normally 2 weeks for 6 weeks) at the time of your first visit in order to secure your best available time with your Physical Therapist.

There is a tendency for patients to drop out of physical therapy when the pain is under control. This is human nature; but what we find is that if you stop at that point, you never fully deal with the underlying causes of your condition, which often results in a return of your condition. I recommend you speak with your physical therapist and/or our patient representatives Tiffany or Vonceia - in order to handle anything that might contribute to your dropping out and not fully resolving your problem. We also recommend that you schedule an appointment to try our post rehab Wellness & Fitness Program. (Discuss this when you are getting ready for discharge to see if it would be appropriate for you.)

Please let us know how you are progressing by filling out a success story form each time you have a win in your therapy. These stories are also forwarded to your doctor and can be used (with your permission) to encourage other patients who can't see the light at the end of the tunnel.

Sincerely,

Ann Duffy M.A., P.T
Owner

Duffy & Bracken
WELLNESS & FITNESS • PHYSICAL THERAPY, P.C.

Medical History Intake Form

Name ____________________________ Date of Birth__________________ Age ________

Referred by:__________________________ Email______________________________

Height_______________ Weight____________(*therapist calculate BMI*)_______________

Are you currently under the care of an internist or family doctor or cardiologist? (*circle*)
Name and Phone Number____

Circle any of the following, which you have had or have at present:

Heart Failure, Disease or Attack	Diabetes or Impaired Glucose	Cough
High Blood Pressure	Emphysema	HIV/AIDS
Fainting or Dizzy Spells	Kidney Disease	Sickle Cell Disease
Heart Surgery	Bladder Trouble	Psychiatric Treatment
Angina/Chest Pain	Liver Disease	Artificial Joint
Heart Pacemaker	Asthma	Rheumatism
Artificial Heart Valve	Emphysema	Ulcers
Swollen Ankles	Cancer or Tumor	Tuberculosis
Stroke	Chemotherapy	Syphilis
Heart Murmur	Radiation Treatment	Gonorrhea

Do you have a family history of cardiovascular disease (*Sudden death due to Cardiovascular event before age 55 in male immediate family or before age 65 in female immediate family*)?
____

Are you taking medication for high cholesterol or hypertension? Has a doctor ever told you that you have high cholesterol? ____

Are you currently on medications now?
List____

Have you taken any medications or drugs during the past two years for other conditions?
List medication and condition____

Do you smoke cigarettes? Y N How often?____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ____________________________________

Are you on a special diet? ____

Do you exercise regularly? (*specify*)____

Do you have any disease, condition or problem not listed here? (*specify) (include past surgeries*)
____

WOMEN: Are you pregnant?	YES	NO
Are you practicing birth control?	YES	NO
Do you anticipate becoming pregnant?	YES	NO

To the best of my knowledge, all of the above answers are true and correct. If I ever have any changes in my health, or if my medications change, I will inform my treating physical therapist at the next appointment.

____
Signature of Physical Therapist Date

____
Signature of Patient, Parent or Guardian Date

Patient Name ______________________ Date ______________

1. Describe your symptoms ______________________

a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms

3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays date: __________ ③ CT Scan date: __________
② MRI date: __________ ④ Other date: __________

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. What is your occupation?

① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature ______________________ Date ______________

Duffy & Bracken

WELLNESS & FITNESS • PHYSICAL THERAPY, P.C.

DATE: ____________________

Home Phone: (_____) _________________

Work Phone: (_____) __________________

Cell Phone: (_____) ___________________

Email: ______________________________

Emergency Contact: __________________

Emergency Phone: ____________________

NAME: ___________________________________

ADDRESS: ________________________________

CITY: _____________________________________

STATE: ___________ ZIP ____________

EMPLOYER: ______________________________

ADDRESS: _________________________________

JOB TITLE/OCCUPATION: ___________________

BIRTHDATE: ____/____/____ AGE: ________

SOCIAL SECURITY: ______ - ______-__________

MARITAL STATUS: ________ SEX: ________

HOW DID YOU HEAR ABOUT US? ____

Because physical therapy requires frequent patient visits and new patients referred for treatment need to be scheduled and treated as promptly as possible, tight scheduling procedure is required by this office in order to provide the best of care of all of our patients. When one does not show up for treatment, it is time taken away from others who could utilize that treatment time.

We advise you to consider the importance of attending your scheduled treatment. Please help us to give you and all of our patients the best service possible.

SIGNED: ____

Duffy & Bracken
WELLNESS & FITNESS • PHYSICAL THERAPY, P.C.

Patient Acknowledgement of Understanding of the Direct Access to Physical Therapy Regulations

As of November 23, 2006, people in New York who need physical therapy services can go directly to their physical therapist without having to wait for a prescription from a physician. This DIRECT ACCESS TO PHYSICAL THERAPY LEGISLATION allows physical therapists to treat a patient for 10 visits or for a period of 30 days (whatever comes first) before a prescription from a physician must be obtained to continue physical therapy. Exceptions are no-fault and workers compensation, which still require a prescription at the first visit.

This is to acknowledge that I understand the New York State Direct Access to Physical Therapy Law and will obtain a prescription from my physician (either a specialist or primary care physician) after 10 visits or within 30 days of the start of my treatment at Duffy & Bracken Physical Therapy P.C.

____
Printed Name of Patient

______________________________ ________________
Signature of Patient *Date*

Duffy & Bracken
WELLNESS & FITNESS • PHYSICAL THERAPY, P.C.

75 MAIDEN LANE - NEW YORK, NY 10038 - PHONE (212) 402-5430 – FAX (212) 402-5432
WWW.DUFFYANDBRACKEN.COM

NO-SHOW AND LATE CANCELLATION POLICY

Please read and sign the following policy.

Because physical therapy requires frequent patient visits and new patients referred for treatment need to be scheduled and treated as promptly as possible, a tight scheduling procedure is required by this office in order to provide the best care to all our patients. When one does not show up for treatment, or cancels the same day, it is time taken away from others who could utilize that treatment time.

Duffy & Bracken charges a $75.00 no-show/late cancellation fee. We define a NO-SHOW as a patient who does not appear for a scheduled appointment, or is more than 15 minutes late for their appointment time. We define a LATE-CANCELLATION as a patient who does not give us 24-hour notice of cancellation. **IMPORTANT NOTE**: Monday appointment cancellations must be called in ***by 3:30 p.m***. ***on the Friday before*** your appointment. **The fee is your responsibility and will not be paid by your insurance company. It must be paid in full before your next treatment can be given.**

We advise you to consider the importance of attending your scheduled treatment. Please help us to give you and all of our patients the best treatment possible.

PAYMENT RELEASE AUTHORIZATION

I request that payment of authorized health benefits be made either to me or on my behalf to Duffy & Bracken Physical Therapy PC for any services furnished to me by the physical therapist. I authorize any holder of medical information about me to release to a representative of Duffy & Bracken any information needed to determine these benefits or the benefits payable for related services.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have received and reviewed Duffy & Bracken Physical Therapy PC Notice of Privacy Practices. If I have any questions, I can call the Practice at (212) 402-5430

I HAVE READ AND UNDERSTAND THE TERMS OF THE ABOVE POLICIES:

Signed: ____ Date: ______________