

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Reason for Treatment: \_\_\_\_\_  
 Other Conditions: \_\_\_\_\_

Do you have a Health Care Proxy?

Yes If Yes Copy Requested Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 No If No  Documents will be offered on arrival  Documents Declined

Upon arrival did patient bring documents  Yes  No

Current Medications (include over the counter Medications, Herbs and Vitamins): \_\_\_\_\_

SURGERY/PROCEDURE/XRAYS FOR CURRENT CONDITION	RESULTS IF KNOWN	DATE

ALLERGIES:  YES  NO (MEDICINE, FOOD, DRUG, AND LATEX)  
 REACTION - EXPLAIN \_\_\_\_\_

**MEDICAL HISTORY: (check box if applicable)**

- |  |  |
|--|--|
| <input type="checkbox"/> STROKES                       | <input type="checkbox"/> BRONCHITIS                |
| <input type="checkbox"/> AORTIC ANEURYSM               | <input type="checkbox"/> DIABETES                  |
| <input type="checkbox"/> BLOOD CLOT                    | <input type="checkbox"/> HYPOGLYCEMIA              |
| <input type="checkbox"/> ANEMIA                        | <input type="checkbox"/> KIDNEY DISEASE/DIALYSIS   |
| <input type="checkbox"/> HIGH BLOOD PRESSURE           | <input type="checkbox"/> ARTHRITIS/GOUT            |
| <input type="checkbox"/> FRACTURES                     | <input type="checkbox"/> CELLULITIS LOCATION _____ |
| <input type="checkbox"/> METAL IMPLANT                 | <input type="checkbox"/> CROHNS DISEASE            |
| <input type="checkbox"/> SEIZURES                      | <input type="checkbox"/> DIVERTICULITIS/COLITIS    |
| <input type="checkbox"/> HEADACHES                     | <input type="checkbox"/> CANCER TYPE _____         |
| <input type="checkbox"/> PACEMAKER                     | <input type="checkbox"/> LYMPH NODE DISSECTION     |
| <input type="checkbox"/> HEART DISEASE/CORONARY BYPASS | <input type="checkbox"/> CHEMOTHERAPY              |
| <input type="checkbox"/> CONGESTIVE HEART FAILURE      | <input type="checkbox"/> RADIATION LOCATION _____  |
| <input type="checkbox"/> HEART ATTACK                  | <input type="checkbox"/> OTHER _____               |
| <input type="checkbox"/> COPD/EMPHYSEMA/ASTHMA         |  |

- Have you had any recent illness within the last 3 weeks (e.g. colds, influenza, bladder/kidney infection, or cellulitis)  
 Yes  No If yes, describe \_\_\_\_\_
- Have you noticed any lumps or thickening of skin or muscle anywhere on your body?  
 Yes  No If yes, describe \_\_\_\_\_
- Do you have any sores that have not healed, or any changes in size, shape or color of wart or mole?  
 Yes  No If yes, describe \_\_\_\_\_
- Have you had any unexplained weight loss in the last month?  Yes  No If yes, how much? \_\_\_\_\_
- Do you smoke?  Yes  No If yes, amount daily \_\_\_\_\_ Number of years \_\_\_\_\_ Have you quit \_\_\_\_\_ Date \_\_\_\_\_
- How much caffeine do you consume daily, including soft drinks, coffee, tea or chocolate? \_\_\_\_\_
- Are you on a special diet prescribed by a physician?  Yes  No If yes, explain \_\_\_\_\_
- Have you had any unexplained pain?  Yes  No  
 If yes, what has been used (include home remedies) \_\_\_\_\_

**CURRENT LEVEL OF FITNESS**

Please describe any exercises/sport you are currently involved in: \_\_\_\_\_

When did you start? \_\_\_\_\_ How often \_\_\_\_\_

Are there any activities that you cannot do now that you could do before your injury or illness? If yes please describe:

Do you ever experience any shortness of breath or difficulty breathing (e.g. walking, climbing stairs)?

**WORK ENVIRONMENT (Does your job involve):**

Please check:

- Prolonged sitting (e.g. desk, computer, driving)
- Prolonged standing (e.g. equipment, operator, sales, clerk)
- Prolonged walking (e.g. mill worker, delivery service)
- Use of large or small equipment (e.g. telephone, forklift, typewriter, drill press, and cash register)
- Lifting, bending, twisting, climbing, turning
- Exposure to chemicals or gases

Other, please describe \_\_\_\_\_

What are your goals or expectations from your Physical Therapy program? \_\_\_\_\_

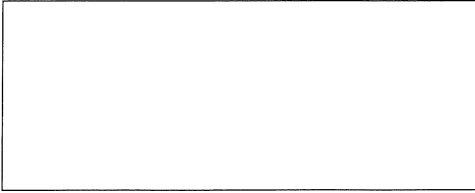
Patient Information Completed by:  Patient  Family  Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Do not write below this line \_\_\_\_\_

Therapists Comments: \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_



**OUTPATIENT REHABILITATION SERVICES**  
Phone: (631) 476-2737 • Fax: (631) 686-2543

**CONTRACT FOR CARE**

The following policies have been instituted so that you can receive the maximum benefits from rehabilitation

**Attendance** - You will receive the greatest benefit from your therapy by being consistent with your prescribed treatment program and by receiving care by your assigned "team" of therapists including Physical Therapist, Physical Therapist Asst., Occupational Therapist, Certified Occupational Therapist Asst. and/or Speech-Language Pathologist. The frequency and duration of your treatment will be decided based on the recommendations of your Physician, Therapy Team, personal schedule and time required to reach reasonable functional goals.

**Appointments** - We make every attempt to see you at your scheduled appointed time so please notify front desk staff if your wait for your scheduled appointment time is longer than 10 minutes.

**Lateness, No Show & Cancellations** - As part of your consent for treatment, you agree to notify the office at least 24 hours in advance if you need to cancel an appointment. You can leave a message any time of day or night, if the office is not open. Please call if you know that you will be late for your scheduled appointment time. This allows your Therapist to effectively assist other patients who may be in need of services. Depending on the day's schedule, the Therapist has the discretion to reschedule you that day. If you know that you will be unable to make your scheduled appointment, please call to cancel so that we can schedule another patient in your time slot. If you cancel an appointment within 24 hours of your appointment time, or do not come to your appointment, you will be sent a letter reminding you of each missed appointment. Once you've missed four appointments without proper notice, you may receive a letter discharging you from your therapy. We reserve the right to bill you \$20.00 for missed appointments.

**Co-payments** - Copayments are due at the start of each treatment session. Your co-pay is decided by your insurance provider and we are not permitted to waive copayments. Authorization Coordinators are available to assist you with questions regarding your co-payment. If you require a payment plan, you may speak with our billing department staff.

**Email** - By providing your e-mail address above, you are agreeing to receive at such e-mail address (1) e-mails requesting your participation in surveys about your care, and (2) e-mails providing you with information regarding access to the FollowMyHealth patient portal.

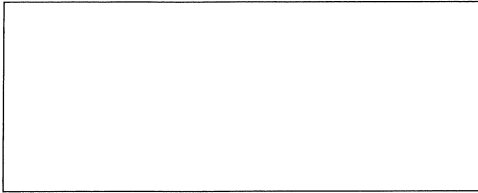
**Resuming Therapy** - To resume therapy after being discharged, a new prescription from your Physician is required. Additionally, your insurance provider may require you to obtain a new referral.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**INFORMED CONSENT FOR PHYSICAL THERAPY / OCCUPATIONAL THERAPY / SPEECH-LANGUAGE PATHOLOGY**  
Physical, Occupational, and Speech-Language Pathology involve the use of many different types of evaluations and treatment procedures to help improve your function. As with all forms of treatment, there are benefits and risks involved. The possibility exists that your condition may not improve or could get worse. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response. Your treatment plan is based on your history, diagnosis, symptoms, testing results and functional needs. At any time, you have the right to discuss with your therapist your treatment as well as the risks, benefits and likelihood of achieving your therapy goals. You have the right to decline any portion of your treatment at any time before or during your treatment session. **I acknowledge that my treatment program has been explained including the likelihood of achieving goals of care, and all of my questions have been answered to my satisfaction. I understand the risks associated with a rehabilitation program as outlined to me, and I wish to proceed.**

_____ Patient/Guardian/Relative's Signature	_____ Date	_____ Time	_____ Print Name and Relationship to Patient
_____ Clinician Signature	_____ Date	_____ Time	

**Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777**



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please list below any medications that you are currently taking for medical and psychiatric illnesses, and the name of the practitioner who prescribes them. Please include any over the counter medications, herbal remedies or dietary supplements.

Medication	Dose	Route	Directions	Prescriber

Form Completed By: \_\_\_\_\_ Date: \_\_\_\_\_