181 Main Street
Monroe, CT 06468
Phone: 203-445-9843
Fax: 203-445-9847

PATIENT INFORMATION			HOW DID YOU HEAR ABOUT US? _____
First Name:	Last Name:		Middle Initial:
Address:	City:	State:	Zip:
Email Address:	Emergency #: ( ) -		
Date of Birth: / /	☐ Male ☐ Female	S.S. #: - -	DX:
Home Phone: ( ) -	Alternative Phone: ( ) -	Emergency #: ( ) -	
May we send an email or leave messages regarding appointments or treatment on your answering machine? ☐ Yes ☐ No			

WORK INFORMATION		
Employer:	Work Phone: ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring MD:	Phone: ( ) -
PCP:	Phone: ( ) -

INSURANCE INFORMATION: ☐ PI ☐ Workers' Comp ☐ Auto Accident	Date of Injury: / /
Name of Primary Insurance:	
Subscriber:	Date of Birth: / /
ID. #:	Group/Policy #: Policy Holder's SSN:
Place of Employment:	
In-Network: Rep/Date:_____ Eff Date: _____ Copay/Ded:_____ OOP _____	
PCP / Spec ref req. ☐ Y / ☐ N Prior Auth/Notification: ☐ Y / ☐ N _____	
☐ Per Cal Yr / ☐ Cons / ☐ Per Cond / Per Lifetime ☐ PT / ☐ OT / ☐ S P / ☐ CHIRO combined	
Name of Secondary Insurance:	
Subscriber:	Date of Birth: / /
ID. #:	Group/Policy #
Place of Employment:	
In-Network: Rep/Date:_____ Eff Date: _____ Copay/Ded:_____ OOP _____	
PCP / Spec ref req. ☐ Y / ☐ N Prior Auth/Notification: ☐ Y / ☐ N _____	
☐ Per Cal Yr / ☐ Cons / ☐ Per Cond / Per Lifetime ☐ PT / ☐ OT / ☐ S P / ☐ CHIRO combined	

OUT-OF-NETWORK BENEFITS (Please initial and sign below)

- I agree to give at least 6 hours notice of cancellation and understand I may be taken off program if I repeatedly no-show or cancel without notice. _____
- My benefits and copay/deductible have been explained to me _____
- I am responsible for informing Zielinski Physical Therapy, P.C on how many PT/CHIRO visits used this year _____
- I am responsible for informing Zielinski Physical Therapy, P.C. of any changes to my insurance policy which may affect requirements for authorization and payment for services rendered. _____
- I authorize treatment by Peter S. Zielinski Physical Therapy, P.C. _____
- I authorized the release of information necessary to determine the liability for payment and to obtain reimbursement on any claim. _____
- I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance, and other health plans to: Peter S. Zielinski Physical Therapy, P.C. I understand my benefits as explained above. _____
- I understand that this statement does not relieve my financial responsibility for any unpaid charges or balances from any insurance company, (all rules and regulations of insurance companies that the Peter S. Zielinski Physical Therapy, P.C. participates with apply.) _____

PATIENT /GUARDIAN SIGNATURE DATE

Zielinski and Associates PHYSICAL THERAPY

181 Main Street
Monroe, CT 06468
Phone: 203-445-9843
Fax: 203-445-9847

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Arrhythmia(s)	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker?	☐	☐

MUSCLE CONDITION	YES	NO
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Muscular Dystrophy	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
Rheumatoid Arthritis	☐	☐
Osteoarthritis	☐	☐

OTHER CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Parkinson's Disease	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Anxiety	☐	☐
Cancer	☐	☐
Depression	☐	☐
Stroke	☐	☐
Thyroid Condition	☐	☐
Other:		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			
	☐ Other			

What types of exercise do you perform? _____

What things cause stress in your life?

Are you taking any seizure medication? ☐ Yes ☐ No If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ Yes ☐ No If yes list name: _____

List all medications you are currently taking: _____

List all surgeries (including dates): _____

Are you pregnant? ☐ Yes ☐ No What week? _____

Have you had any injuries related to work? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had any auto accidents? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ Yes ☐ No Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

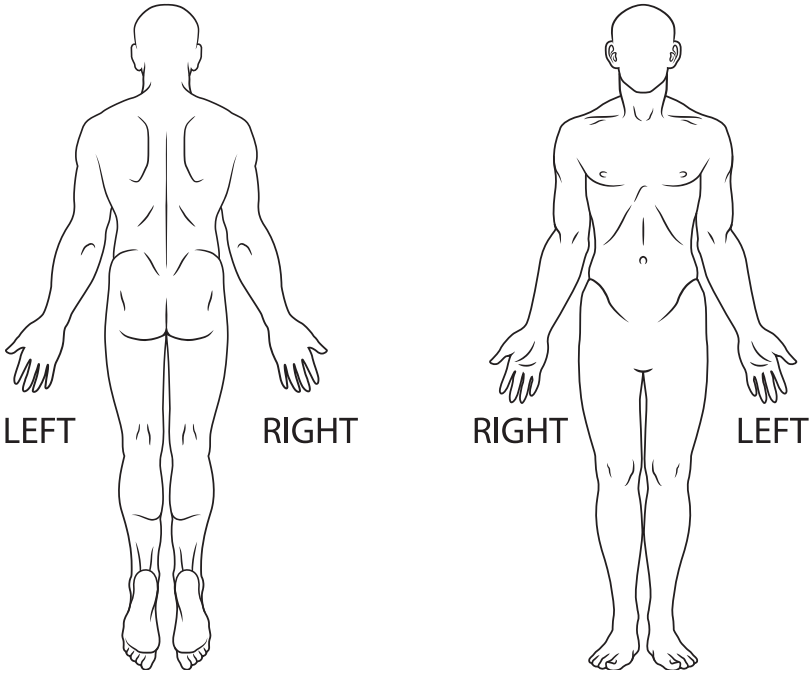
Pain and Symptom Status Report

Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMM	— — —	0 0 0 0
M	— —	0 0 0

Pins and Needles	Stabbing	Other
□ □ □ □ □ □	/////	x x x x
□ □ □ □	////	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>LOWEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>HIGEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: _____

_____

What goals do you wish to achieve in physical therapy? _____

_____

_____

_____

_____