Corinthian Physical Therapy

124 East 40th Street New York, NY 10016-1765 / (212) 986-4161

PHYSICAL THERAPY SERVICES

Patient Information

First Name: ____________________ Last Name: ____________________ DOB: ____/____/_____

Address: ______________________________________ City: _______________________ State: _____

Zip Code: __________ Home Phone: (____) ______- ______ Cell Phone: (____) ______- _______

Email: _______________________________________

Emergency Contact Name: _________________________________ Phone: (____) ______- _______

Referring Physician Information

First Name: _______________________________ Last Name: ____________________________

Address: _____________________________________ City: _______________________ State: _____

Zip Code: __________ Office Phone: (____) ______- _______ Office Fax: (____) ______- _______

Insurance Information

Insurance Name: ___________________________ Insurance Phone: ___________________________
Insurance ID No. ___________________________ Group No. ________________________________
HMO ____ PPO_____ *(check one)*

Current Injury

When did the injury occur? ____/____/_____ Surgery Performed? Yes _______ No ______

How did the injury occur? ____

What were you capable of doing before the injury? *(check any that apply)*
Self-Care ____ (i.e. bathing) Work ____ Caregiving ____
Ambulation/Mobility ____ Community Integration/Access ____
Other ____

Describe your symptoms and/or activity limitations: ____

____

Pain Scale: 0 = None 5 = Moderate 10 = Extreme

	0	1	2	3	4	5	6	7	8	9	10
At worst:	o	o	o	o	o	o	o	o	o	o	o
Current:	o	o	o	o	o	o	o	o	o	o	o
At best:	o	o	o	o	o	o	o	o	o	o	o

(fill in the circle under the corresponding number)

Medical / Injury History

Circle the condition(s) that you have been diagnosed with:

Anemia	Circulation problems	Heart disorders	Multiple Sclerosis
Arthritis	Diabetes/ high blood sugar	High blood pressure	Muscular Dystrophy
Asthma	Depression	Infectious diseases	Osteoporosis
Bowel/Bladder problems	Epilepsy	Kidney problems	Parkinson's disease
Cancer: _________*(type)*	Fatigue	Low blood sugar/ hypoglycemia	Repeated infections
Chemical Dependency	Head Injury	Lung problems	Skin diseases

Please use the following lines to explain any circled above: ___________________________________

____

____

Please describe any past injuries for which you have been treated: ______________________________

____

____

Have you had any diagnostic tests for your current injury (MRI, x-ray, etc.)? Yes ____ No ____
If yes, what were the results? ____

Current Medication

Prescription: ____

Vitamin/Mineral/Dietary Supplements: ____

Over-the-Counter: ______________________________ Other: _______________________________