Cornerstone Physical Therapy Associates

PATIENT INFORMATION			
First Name:	Last Name:		
Address:	City:	State:	Zip:
E-Mail Address:	Home Phone: ( ) -	Birth Date:	Age:
	Secondary Phone: ( ) -	Spouse Name:	
How did you hear about Cornerstone Physical Therapy Associates?			

WORK INFORMATION		
Occupation:	Work Phone: ( ) -	Number of hours worked per day:
Employer:	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Doctor:	Referring Dr. Phone: ( ) -
Primary Care Doctor:	Primary Care Dr. Phone: ( ) -

INSURANCE INFORMATION	
Primary Insurance Provider:	
Subscriber's Name:	Birth Date:
ID Number:	Group #:
Patient's Relationship to Subscriber:	
PLEASE FILL OUT THE FOLLOWING IF YOU HAVE A SECONDARY INSURANCE POLICY	
Secondary Insurance Provider:	
Subscriber's Name:	Birth Date:
ID Number:	Group #:
Patient's Relationship to Subscriber:	

AUTO OR WORK INJURY INFORMATION *Please complete if this treatment is related to an auto or work injury claim.*			
Insurance Name: ☐ Auto ☐ Labor & Industries			
Adjuster/ Claim Manager:		Phone: ( ) -	Ext:
Address:	City:	State:	Zip:
Claim #:	Accident Date:	Cause:	

ATTORNEY INFORMATION *Please complete if this treatment is related to an injury or disability claim.*			
Name:	Law Firm:		
Address:	City:	State:	Zip:

EMERGENCY CONTACT INFORMATION		
Name of Emergency Contact:		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Cornerstone Physical Therapy Associates. I understand that I am financially responsible for my balance. I authorize Cornerstone Physical Therapy Associates to release any information required to process my claims.

_____ _____

PATIENT/ GUARDIAN SIGNATURE DATE

Cornerstone Physical Therapy Associates

PAST MEDICAL HISTORY FORM **Patient Name:**_____

Please indicate below if you have any history of the following conditions:

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐
HEART DISEASE	**YES**	**NO**
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Stroke (CVA)	☐	☐
Atrial fibrillation (AFIB)	☐	☐
Heart Murmur	☐	☐
Pacemaker or Defibrillator	☐	☐
MUSCLE & JOINT CONDITIONS	**YES**	**NO**
Carpal Tunnel Syndrome	☐	☐
Tennis Elbow Syndrome	☐	☐
Back/Neck Problems	☐	☐
Fracture/Strain/Sprain	☐	☐
LUNGS	**YES**	**NO**
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

OTHER CONDITIONS	YES	NO
Arthritis	☐	☐
If yes, Rheumatoid or Osteo?		
Diabetes	☐	☐
Cancer	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy or Seizure	☐	☐
Fibromyalgia	☐	☐
Cerebral Palsy	☐	☐
Vertigo	☐	☐
Depression	☐	☐
Hearing Loss	☐	☐
Vision Issues/ Glaucoma	☐	☐
Hepatitis	☐	☐
Thyroid Issues	☐	☐
Chemical Dependency	☐	☐

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
☐ None	☐ Sitting	☐ Low	☐ Smoking
☐ 1-2x per week	☐ Standing	☐ Medium	☐ Alcohol
☐ 3-4x per week	☐ Light Labor	☐ High	☐ Coffee/Soda
☐ 5x per week or more	☐ Heavy Labor		

List all medications you are currently taking: _____

_____

List all surgeries (and year of surgery):_____

_____

Have you had any work-related injuries? _____

Have you had any auto-accident injuries? _____

Have you had Physical Therapy, Massage Therapy, or Chiropractic care? _____

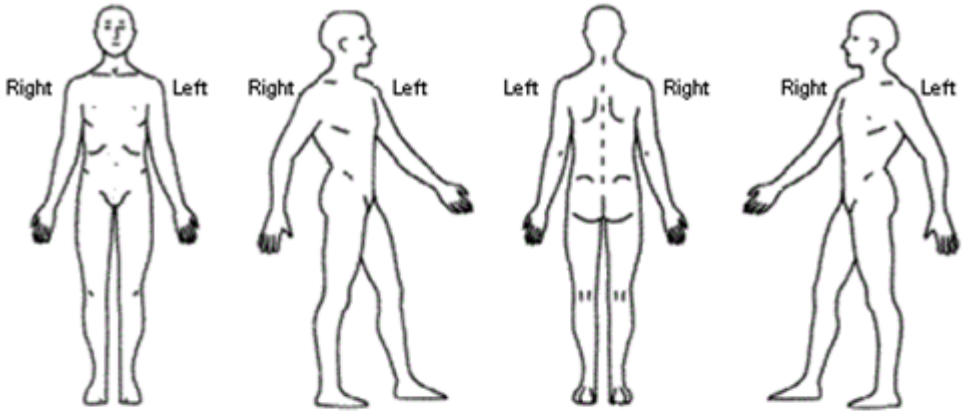
_____ _____

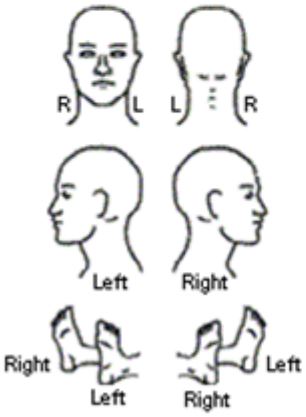
Signature of Patient, Parent, Guardian, or Legal Representative Date

Pain and Symptom Status Report

Name: _____ Date:_____

Using the diagram below, circle the area in which you are having pain or complications.





What sensation do you feel in these areas?
(*Please Circle*)

Ache	Burning
Numbness	Stabbing
Tingling/Tickling	Pins/Needles
Other: _____	

How often does this sensation occur:

_____

What activities, if any, trigger this sensation :

_____

Chief Complaint and Visual Analog Scale
My Chief Complaint: _____
Date of First Occurrence of this Symptom:_____
2nd Complaint: _____
3rd Complaint:_____
Pain Scale
No Pain 1 2 3 4 5 6 7 8 9 10 Most Severe Pain
Please rate your CURRENT level of pain: _____
What number represents your level of pain on AVERAGE: _____
What number represents your pain at its WORST: _____

Please list any change in medications since your last evaluation: _____

CORNERSTONE
PHYSICAL THERAPY ASSOCIATES

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective: January 1, 2019

This Notice of Privacy Practices applies to the following organizations.

Cornerstone Physical Therapy Associates
1338 Bristol Pike Suite 203, Bensalem, PA 19020 PH: 215-633-9080 FX: 215-633-9915
740 Edison Furlong Road, Furlong, PA 18925 PH: 215-794-2611 FX: 215-794-8007
322 W. Bridge Street, New Hope, PA 18938 PH: 267-740-2954 FX: 267-740-7902

www.cornerstonepta.com

I have read and acknowledge receipt of this Notice of Privacy Practices

_____ _____
Signature *Date*