WELCOME AND THANK YOU FOR CHOOSING OUR FACILITY TO PROVIDE YOUR CARE.
We need your doctor's referral or prescription and a copy of your driver license and insurance card.
Again, thank you and welcome!

PATIENT REGISTRATION FORM

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELLPHONE: _____ HOME PHONE: _____

EMAIL: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION

Check if applicable: ☐ **I choose to pay out-of-pocket.**

PRIMARY INSURANCE: _____ POLICY #: _____

SECONDARY INSURANCE: _____ POLICY #: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DOB: _____ RELATIONSHIP TO PATIENT: _____

WORKER'S COMPENSATION / NO FAULT CASE: _____

CASE COORDINATOR NAME: _____

PHONE: _____ EXTENSION: _____ FAX: _____

Consent to Evaluation and Treatment, Assignment of Benefits, Release of Information and Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned hereby authorize Motion Plus Physical Therapy, PC and/or Alberto O. Ferrer, Jr., PT and/or Irene M. Ferrer, PT to be my physical therapy provider. I authorize to administer such evaluation and treatment in its/their professional judgment that are deemed necessary or advisable to care for the above-named patient or me. I acknowledge that no guarantees or assurances have been made to me concerning the results of the evaluation and treatment.

I hereby grant authorization for the release of any information concerning my case or the above-named patient to my insurance company or other third party required for the processing of this claim. I also authorize my insurance benefits to be paid directly to Motion Plus Physical Therapy, PC and/or Alberto O. Ferrer, Jr., PT and/or Irene M. Ferrer, PT and I am responsible for non-covered services including copays and deductibles. I authorized the use of this signature on all my insurance submissions.

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and have therefore been advised how the Protected Health Information (PHI) about me may be used and disclosed and how I may obtain access to and control this information.

I CONFIRM THAT I FULLY UNDERSTAND THE ABOVE.

PATIENT/GUARDIAN SIGNATURE: **X** _____ DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

REASON FOR SEEKING PHYSICAL THERAPY

1. **What is the main reason you are seeking physical therapy?**
   - ☐ Pain management ☐ Injury recovery ☐ Mobility and balance issues ☐ Strength and conditioning
   - ☐ Health and wellness ☐ Education
   - ☐ Post surgical rehabilitation. Specify: _____
   - ☐ Other: _____
2. **Describe your symptoms or condition in detail:**

   _____

   _____

   _____
3. **Have you ever had this same or similar pain or problem before?** ☐ Yes ☐ No If yes, when? Describe:

   _____

   _____
4. **When did your symptoms begin?** Date of onset, if known: _____
   - ☐ Less than 1 week ago ☐ 2–4 weeks ago ☐ 1–3 months ago ☐ Over 3 months ago ☐ Over _____ months ago
   - ☐ Over _____ years ago
5. **How did the issue begin?**
   - ☐ Sudden injury ☐ Gradual onset ☐ Post-surgery ☐ Unknown cause
6. **Describe your pain.** Check all that apply.
   - ☐ Sharp ☐ Dull/achy ☐ Burning ☐ Throbbing ☐ Numbness/tingling ☐ Other: _____

   Rate your pain on a scale of 0 to 10 (**0 = No pain** and **10 = Worst pain imaginable**)

   Current pain level: _____ Worst pain level: _____ Best pain level: _____
7. **What makes your symptoms worse?** Check all that apply.
   - ☐ Standing ☐ Walking ☐ Sitting ☐ Lifting ☐ Bending ☐ Sleeping ☐ Other: _____
8. **What makes your symptoms better?** Check all that apply.
   - ☐ Rest ☐ Heat/ice ☐ Medication ☐ Stretching ☐ Physical activity ☐ Other: _____
9. **Have you had any previous treatment for this condition?** ☐ Yes ☐ No Explain:

   _____
10. **Have you had imaging or tests related to this condition?** Check all that apply.
    - ☐ X-ray ☐ CT scan ☐ EMG ☐ Other ☐ None
11. **How does this condition affect your daily life?** Check all that apply.
    - ☐ Work limitations ☐ Difficulty exercising ☐ Trouble with daily activities ☐ Sleep disturbances
    - ☐ Other: _____

    List one activity you are unable to do that you absolutely want to be able to do again:

    _____
12. **What are your goals for physical therapy?** Check all that apply.
    - ☐ Pain relief ☐ Improved mobility ☐ Strengthening ☐ Return to work or sports ☐ Other: _____
13. **Additional notes:**

    _____

    _____

PATIENT/GUARDIAN SIGNATURE: X _____ DATE: _____

PHYSICAL THERAPY PRE-EXAMINATION INTAKE FORM

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

OCCUPATION (PAST OR PRESENT): _____ Are you working now? ☐ Yes ☐ No

PAST MEDICAL HISTORY (check all that apply)

☐	Hypertension or high blood pressure	☐	Chronic pain (location: _____)
☐	Diabetes	☐	Arthritis
☐	Stroke	☐	Respiratory (e.g. COPD, asthma)
☐	**Heart disease**	☐	Liver disease
☐	**Pacemaker**	☐	Kidney disease
☐	Cancer. Type: _____	☐	Autoimmune disorders
☐	Thyroid disorders	☐	Depression/anxiety
☐	Neurological disorders (e.g. Parkinson's)	☐	Other:
☐	Other:	☐	Other:
☐	**Are you currently pregnant?** ☐ Yes ☐ No	☐	Other:

PAST SURGICAL HISTORY (check all that apply)

☐	Joint replacement: ☐ Knee ☐ Hip ☐ Shoulder	☐	Other:
☐	Back / spine surgery	☐	Other:
☐	Abdominal surgery	☐	Other:
☐	Pelvic surgery	☐	Other:
☐	Heart surgery	☐	Other:
☐	Cancer-related surgery	☐	Other:

FALL HISTORY, LIVING SITUATION & LIFESTYLE

Have you fallen in the past year? ☐ Yes ☐ No If yes, how many times? _____ Were you injured? ☐ Yes ☐ No

If injured, explain: _____

Do you use any assistive device? ☐ Cane ☐ Walker ☐ Wheelchair ☐ None ☐ Other: _____

Do you have any balance issues? ☐ Yes ☐ No

Social history / living situation: Lives: ☐ Alone ☐ With family ☐ Assisted living ☐ Other: _____

How many steps do you have at home? _____ Do you have a railing? ☐ Yes ☐ No

Physical activity level: ☐ Sedentary ☐ Light activity ☐ Moderate exercise ☐ High intensity exercise

Smoking history: ☐ Never smoked ☐ Former smoker (quit year: _____) ☐ Current smoker (packs/day: _____)

Alcohol use: ☐ None ☐ Occasional ☐ Moderate (1–2 drinks/day) ☐ Heavy (3+ drinks/day)

Recreational drug use: ☐ None ☐ Yes (type: _____)

Current Medications

List all medications you are currently taking, including prescription, over-the-counter and supplements.

Medication name	Dosage	Frequency	Reason for taking

NOTICE OF PRIVACY PRACTICES

Effective Date: March 27, 2025

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy

Your health information is personal, and we are committed to protecting it. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

How We May Use and Disclose Your Health Information

We may use and disclose your PHI for the following purposes:

Treatment: To provide, coordinate, or manage your healthcare services.

Payment: To obtain reimbursement from your insurance company or other third parties.

Healthcare Operations: To assess and improve the quality of our services.

Legal Requirements: When required by law, such as in response to court orders or law enforcement requests.

Public Health & Safety: To prevent disease, report adverse reactions, or address other public health concerns.

Workers' Compensation: For work-related injury or illness claims.

Your Rights Regarding Your Health Information

You have the following rights concerning your PHI:

Access Your Records: You may request a copy of your medical records.

Request Amendments: You may ask us to correct your records if you believe they are incorrect or incomplete.

Request Restrictions: You may request limits on how we use or disclose your information.

Confidential Communications: You may request that we communicate with you in a certain way or at a specific location.

Receive an Accounting of Disclosures: You may request a list of times we shared your PHI for purposes other than treatment, payment, or healthcare operations.

File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Changes to This Notice

We reserve the right to update this Notice at any time in accordance with federal, state, and local rules, regulations, and guidelines. Any changes will apply to all PHI we maintain, and we will provide an updated Notice upon request.

Contact Information

If you have any questions or grievance about your privacy, this Notice or your rights, please contact: Motion Plus Physical Therapy, PC at 1225 Richmond Road, Staten Island, NY 10304. Phone: 718.477.2971

Acknowledgment of Receipt

I acknowledge that I have received and reviewed Motion Plus Physical Therapy, PC's Notice of Privacy Practices.

PATIENT/GUARDIAN SIGNATURE: **X** _____ DATE: _____