HORSEHEADS COMPREHENSIVE PHYSICAL THERAPY, PC
2758 WESTINGHOUSE ROAD
HORSEHEADS, NEW YORK 14845
P/607-795-1539 F/607-795-1918

NAME_____ DOB_____

ADDRESS_____

REFERRING PHYSICIAN_____PCP_____

PHONE: HOME_____C#_____EMAIL_____

OCCUPATION_____INJURY: WORK/AUTO RELATED? DOI_____

HERE TODAY BECAUSE_____

RELATED DIAGNOSTIC TESTS? X-RAY MRI CT-SCAN OTHER_____WHERE_____

SURGICAL HISTORY_____

GENERAL HEALTH

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?

ARTHRITIS/SWOLLEN JOINTS	Y N
CANCER/CHEMO/RADIATION (CIRCLE)	Y N
CONCUSSION	Y N
CURRENTLY PREGNANT	Y N
DIABETES	Y N
EMOTIONAL/PSYCHOLOGICAL PROBLEMS	Y N
HIGH BLOOD PRESSURE	Y N
METAL IMPLANTS	Y N
MS	Y N
OSTEOPOROSIS	Y N
PARKINSON'S	Y N
SEIZURES/EPILEPSY	Y N
STROKE/TIA	Y N

NECK-JAW-HEAD

FACIAL PAIN	Y N
CLICKING WHEN OPEN/CLOSE MOUTH	Y N
HEADACHE DAILY/WEEKLY	Y N
DRY MOUTH UPON WAKING	Y N
PAIN IN FRONT OF EAR	Y N
EAR FULLNESS OR RINGING IN EAR	Y N
TENSION AT BASE OF SKULL WITH NECK TURNING WHEN UPRIGHT	Y N

VISION

CONTACTS/GLASSES (CIRCLE)	Y N
BIFOCALS/TRIFOCALS/INVISALIGN (CIRCLE)	Y N
BLURRY VISION	Y N
DIFFICULTY NIGHT DRIVING	Y N
FEEL DIZZY	Y N
LIGHT SENSITIVITY	Y N
OCCASIONALLY BUMPING INTO OBJECTS	Y N

BREATHING

SNORE	Y N
DIFFICULTY BREATHING IN DAILY ACTIVITIES i.e climbing stairs	Y N
WAKING UP TIRED	Y N
ASTHMA/USE INHALER	Y N
USE ELEVATED SLEEP POSITION	Y N
HAVE SLEEP APNEA DIAGNOSIS	Y N

LUMBO-PELVIC-FEMORAL

URINE LEAKAGE WHEN YOU COUGH, SNEEZE, LAUGH, LIFT, EXERCISE	Y N
URINE LEAK JUST BEFORE GOING TO TOILET	Y N
PLANNING TRIPS BASED ON BATHROOM LOCATIONS	Y N
PAIN, DISCOMFORT OR PRESSURE IN PELVIC AREA WHEN SITTING/STANDING FOR PROLONGED TIME	Y N
FREQUENT STRAINING TO HAVE BOWEL MOVEMENT/EMPTY BLADDER	Y N
SENSATION OF PRESSURE IN LOWER ABDOMEN OR PELVIC AREA	Y N

FEET

OUTSIDE LEG & ANKLE STRAIN	Y N
FLAT FEET	Y N
PAIN IN BOTTOM OF FOOT WHEN STANDING	Y N
BONY BUMP NEAR BIG TOE	Y N
ORTHOTICS OR OTHER FOOT INSERTS	Y N
ONE FOOT TURNS OUT MORE THAN OTHER	Y N
ANKLE INSTABILITY ONE/BOTH (CIRCLE)	Y N

APTA

American Physical Therapy Association

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

Select your Primary Concern

Please Select one [1] Primary Concern that you are currently struggling with:

- ☐ Difficulty lying flat
- ☐ Difficulty rolling over
- ☐ Difficulty Transitioning from lying to sitting
- ☐ Difficulty sitting in a chair
- ☐ Difficulty squatting up and down
- ☐ Difficulty bending and stooping down
- ☐ Difficulty maintaining balance
- ☐ Difficulty kneeling down
- ☐ Difficulty standing
- ☐ Difficulty walking short distances
- ☐ Difficulty walking long distances
- ☐ Difficulty walking outdoors
- ☐ Difficulty climbing stairs
- ☐ Difficulty hopping
- ☐ Difficulty jumping
- ☐ Difficulty running
- ☐ Difficulty pushing objects
- ☐ Difficulty pulling on objects
- ☐ Difficulty reaching for objects
- ☐ Difficulty grasping items securely
- ☐ Difficulty lifting items
- ☐ Difficulty carrying items

Please rate your PRIOR functionality level when performing this activity:

0=Unable to do 10=Fully Able

0	1	2	3	4	5	6	7	8	9	10

MEDICAL HISTORY: CHECK EACH TOPIC THAT RELATES TO YOUR MEDICAL HISTORY

____ALLERGIES	____ALLERGIC TO LATEX	____AMPUTATION	____ANEMIA
____ANGINA	____ASTHMA	____ATAXIA	____BELL'S PALSY
____BLOOD CLOT	____BOWEL/BLADDER	____BRONCHITIS	____CARPAL TUNNEL
____CELLULITIS	____CEREBRAL PALSY	____CONCUSSION	____COPD
____CORONARY	____DEPRESSION	____DIZZINESS	____DRINK ALCOHOL
____EMPHYSEMA	____ENERGY LOSS	____EPILEPSY	____EPSTEIN-BARR
____GOUT	____GUILLIAN-BARRE	____HEADACHES	____HEARING DIFFICULTY
____HEART ATTACK	____HEART DISEASE	____HERNIA	____HIGH BLOOD PRESSURE
____INTRACTABLE PAIN	____KIDNEY DISEASE	____LIPEDEMA	____LOW BLOOD PRESSURE
____LOW BLOOD SUGAR	____LUMPECTOMY	____LUPUS	____LYME DISEASE
____LYMPHEDEMA	____MASTECTOMY	____MS	____NEUROLOGICAL ISSUES
____OSTEOARTHRITIS	____OSTEOPOROSIS	____ON OXYGEN	____PACEMAKER
____PARKINSON'S	____PNEUMONIA	____PREGNANT(CURRENT)	____RHEUM. ARTHRITIS
____SCIATICA	____SEIZURES	____SHORT BREATH	____SLEEP APNEA
____SLEEPING PROB	____SPINAL STENOSIS	____STROKE/TIA	____THYROID
____TOBACCO USE	____TORTICOLLIS	____VARICOSE VEINS	____VASCULITIS
____VERTIGO/BALANCE	____VISION DIFFICULTIES	____WEAKNESS	____WEIGHT LOSS
____WOMEN'S HEALTH ISSUES			

MEDICAL HISTORY

PLEASE SELECT THE BODY REGIONS AFFECTED BY YOUR MEDICAL HISTORY

___ABDOMEN ___ANKLE, LEFT ___ANKLE RIGHT ___ARM LEFT

___ARM RIGHT ___ BUTTOCK LEFT ___BUTTOCK RIGHT ___CHEST LEFT

___CHEST RIGHT ___CRPS LEFT ___CRPS RIGHT ___ELBOW LEFT

___ELBOW RIGHT ___FEET/TOES LEFT ___FEET/TOES RIGHT ___GROIN

___HANDS/FINGERS, ALL ___HANDS/FINGERS LEFT ___HANDS/FINGERS RIGHT

___HEAD LEFT ___HEAD RIGHT ___HIP LEFT ___HIP RIGHT

___INCONTINENCE ___JAW LEFT ___JAW RIGHT ___KNEE LEFT

___KNEE RIGHT ___LEG LEFT ___LEG RIGHT ___LOW BACK LEFT

___LOW BACK RIGHT ___LOW BACK CENTER ___NECK LEFT ___NECK RIGHT

___PELVIC FLOOR ___PELVIS ___RECTAL ___SHOULDER LEFT

___SHOULDER RIGHT ___UPPER BACK LEFT ___UPPER BACK RIGHT

___UPPER BACK CENTER ___VAGINA ___WRIST RIGHT ___WRIST LEFT

___NONE OF THE ABOVE

___OTHER_____

MEDICAL HISTORY

PLEASE SELECT ANY TOPICS RELATED TO YOUR MEDICAL HISTORY

___CANCER ___PRE-DIABETES ___DIABETES TYPE 1

___DIABETES TYPE 2 ___PREVIOUS PT/OT AT HOME ___I LIVE ALONE

___I AM A CAREGIVER FOR SOMEONE ELSE ___ I USE A WALKER

___I USE A CANE ___I USE A WHEELCHAIR ___MY HOME HAS STAIRS

___INFECTIOUS DISEASE ___ OTHER IMPORTANT ISSUES_____

___OTHER SURGERY_____

____I HAVE NO MEDICAL HISTORY TO REPORT

___I PREFER NOT TO REPORT MY MEDICAL HISTORY

LIST YOUR MEDICATIONS:

1._____/DOSAGE_____

2._____/DOSAGE_____

3._____/DOSAGE_____

4._____/DOSAGE_____

5._____/DOSAGE_____

6._____/DOSAGE_____

7._____/DOSAGE_____

8._____/DOSAGE_____

9._____/DOSAGE_____

10._____/DOSAGE_____

11._____/DOSAGE_____

12._____/DOSAGE_____

PLEASE SELECT ANY TOPICS RELATED TO YOUR MEDICAL HISTORY

___JOINT REPLACEMENT(S)

___ANKLE R / L ___ARM R / L ___ELBOW R / L

___FEET/TOES R / L ___HANDS/FINGERS R / L ___HIP R / L

___KNEE R / L ___LEG R / L ___NECK R / L

___SHOULDER R / L ___WRIST R / L

___PINS/ METAL IMPLANTS

___ANKLE R / L ___ARM R / L ___ELBOW R / L

___FEET/TOES R / L ___HANDS/FINGERS R / L ___HIP R / L

___KNEE R / L ___LEG R / L ___NECK R / L

___SHOULDER R / L ___WRIST R / L

___ARTHRITIS

___ANKLE R / L ___ARM R / L ___ELBOW R / L

___FEET/TOES R / L ___HANDS/FINGERS R / L ___HIP R / L

___KNEE R / L ___LEG R / L ___NECK R / L

___SHOULDER R / L ___WRIST R / L

___NUMBNESS/TINGLING

___ANKLE R / L ___ARM R / L ___ELBOW R / L

___FEET/TOES R / L ___HANDS/FINGERS R / L ___HIP R / L

___KNEE R / L ___LEG R / L ___NECK R / L

___SHOULDER R / L ___WRIST R / L

MEDICAL HISTORY (CONT)

HOW OFTEN DO YOU EXERCISE?

___NEVER ___USUALLY ONCE PER WEEK _____USUALLY TWICE PER WEEK

___USUALLY 3 TIMES PER WEEK ___4 OR MORE TIMES PER WEEK

DOES YOUR DAILY ROUTINE OR WORK AGGRAVATE YOUR CONDITION?

___NO

___I AM UNABLE TO PARTICIPATE IN MY NORMAL ROUTINES OR WORK

___MY ROUTINE/WORK AGGRAVATES MY CONDITION 1 DAY PER WEEK

___MY ROUTINE/WORK AGGRAVATES MY CONDITION ABOUT 2 DAYS PER WEEK

___MY ROUTINE/WORK AGGRAVATES MY CONDITION 3 OR MORE DAYS PER WEEK

___MY ROUTINE/WORK AGGRAVATES MY CONDITION EVERY DAY BUT I TRY TO COPE

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR FUNCTIONALITY

DOES YOUR CONDITION IMPACT YOUR ABILITY TO DO YOUR JOB?

___I AM RETIRED ___THE CONDITION PREVENTS ME FROM WORKING

___I CAN ONLY WORK PART TIME ___I CAN WORK BUT WITH GREAT DIFFICULTY

___I CAN WORK WITH MINOR DIFFICULTY ___NO IMPACT ON MY ABILITY TO WORK

___NOT APPLICABLE

DOES YOUR CONDITION IMPACT YOUR ABILITY TO ATTEND SCHOOL?

___THE CONDITION PREVENTS ME FROM ATTENDING SCHOOL

___I AM IN SCHOOL BUT THE CONDITION HAS A BIG IMPACT

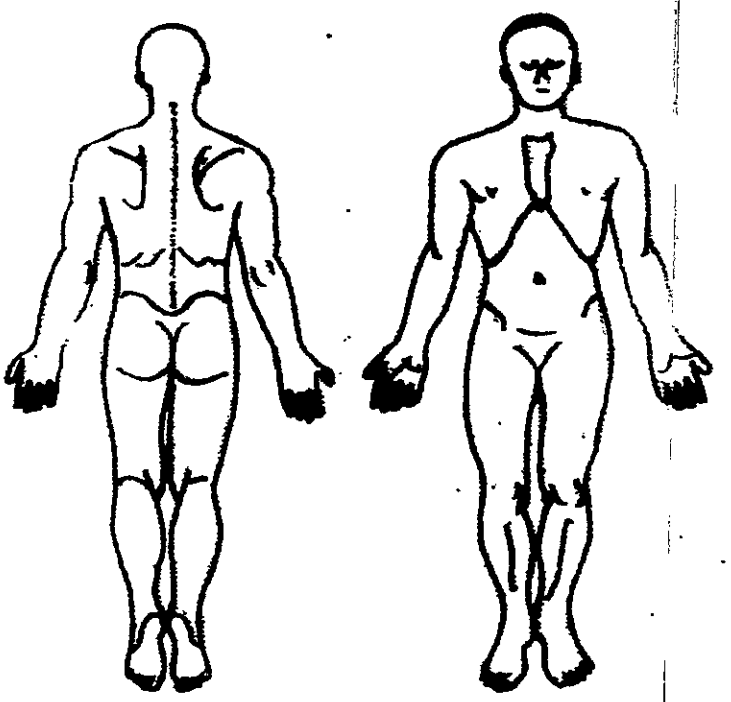
___I AM IN SCHOOL AND THE CONDITION HAS A MINOR IMPACT

___SCHOOL IS NORMAL BUT I CANNOT PARTICIPATE IN SPORTS

___SCHOOL IS NORMAL, NO IMPACT

CIRCLE/MARK THE PART(S) THAT

PROMPT TODAY'S VISIT



___ABDOMEN

___ANKLE/RIGHT

___ANKLE/LEFT

___ARM/RIGHT

___ARM/LEFT

___BUTTOCK/RIGHT

___BUTTOCK/LEFT

___CEREBRAL PALSY

___CHEST/RIGHT

___CHEST/LEFT

___CRPS/RIGHT

___CRPS/LEFT

___ELBOW/RIGHT

___ELBOW/LEFT

___FEET/TOES/RIGHT

___FEET/TOES/LEFT

___GROIN

___HANDS/FINGERS/RIGHT

___HANDS/FINGERS/LEFT

___HEAD/RIGHT

___HEAD/LEFT

___HIP/RIGHT

___HIP/LEFT

___JAW/RIGHT

___JAW/LEFT

___KNEE/RIGHT

___KNEE/LEFT

___LEG/RIGHT

___LEG/LEFT

___LOW BACK/RIGHT

___LOW BACK/LEFT

___LOW BACK/CENTER

___MULTIPLE SCLEROSIS

___NECK/RIGHT

___NECK/LEFT

___PARKINSON'S

___PELVIC FLOOR

___PELVIS

___RECTAL

___SHOULDER/RIGHT

___SHOULDER/LEFT

___UPPER BACK/RIGHT

___UPPER BACK/LEFT

___UPPER BACK/CENTER

___VAGINA

___VERTIGO/BALANCE

___WRIST/RIGHT

___WRIST/LEFT

____NONE OF THESE

PAIN DESCRIPTION:

DESCRIBE WHAT TYPE OF PAIN YOU FEEL RELATED TO YOUR SYMPTOMS

(IF MORE THAN ONE BODY PART IS INVOLVED, PLEASE LABEL EACH ACCORDINGLY)

___ACHING	___BURNING	___CONSTANT	___CRAMPING
___DEEP	___DULL	___HEAVY	___NUMB
___PINS & NEEDLES	___STABBING	___THROBBING	___VARIABLE
___WEAK			

BASED ON YOUR ANSWERS ABOVE, RATE THE PAIN RELATED TO YOUR SYMPTOMS

WHAT WAS YOUR LEVEL OF PAIN WHEN THE CONDITION FIRST OCCURRED?

0/1 = NO PAIN 10 = WORST PAIN EVER

0 1 2 3 4 5 6 7 8 9 10

WHAT IS YOUR CURRENT PAIN LEVEL WHEN IT IS AT ITS WORST?

0/1 = NO PAIN 10 = WORST PAIN EVER

0 1 2 3 4 5 6 7 8 9 10

WHAT IS YOUR CURRENT PAIN LEVEL WHEN IT IS AT ITS BEST

0/1 = NO PAIN 10 = WORST PAIN EVER

0 1 2 3 4 5 6 7 8 9 10

PAIN (cont)

WHAT ACTIVITIES WORSEN YOUR SYMPTOMS?

___REACHING BACK	___LYING FLAT	___GETTING UP OUT OF BED
___DRESSING & GROOMING	___COOKING/PREP	___CARRYING ITEMS
___CLIMBING STAIRS	___SITTING	___TWISTING
___LIFTING ANYTHING	___LIFTING HEAVY ITEMS	___PULLING
___RAISING ARM OVER HEAD	___LOOKING UP/DOWN	___WALKING
___BENDING	___STANDING	

WHAT RELIEVES YOUR SYMPTOMS?

___ICE	___HEAT	___STRETCHING
___EXERCISE	___PAIN MEDICATION	___LYING FLAT
___AVOIDNG ACTIVITY	___NOTHING	

IS THIS A RECURRENCE OF A PRIOR INJURY? ___YES ___NO

IF APPLICABLE, WHEN DID THIS INJURY OCCUR? _____YEAR

PLEASE ENTER YOUR HEIGHT AND WEIGHT

HEIGHT _____FEET _____INCHES

WEIGHT _____

HOW MANY TIMES HAVE YOU FALLEN IN THE PAST YEAR? WERE YOU INJURED?

___0 TIMES

___YES ___NO

___1 TIME

___2 TIMES

___3 TIMES

___4 TIMES

___5 TIMES

___6 OR MORE TIMES

TOBACCO USAGE

ABOUT TOBACCO USAGE, DO YOU:

___SMOKE TOBACCO ___CHEW TOBACCO ___SNUFF TOBACCO

___ALL OF THE ABOVE ___NONE OF THE ABOVE

HAVE YOU EVER RECEIVED ADVICE OR COUNSELING TO HELP YOU STOP USING TOBACCO?

___YES I HAVE RECEIVED ADVICE AND/OR COUNSELING

___NO, I HAVE NOT RECEIVED ADVICE AND/OR COUNSELING

END

MEDICALLY INFORMED CONSENT, ASSIGNMENT & RELEASE

I VOLUNTARILY CONSENT TO PHYSICAL THERAPY TREATMENT AND SERVICES DEEMED NECESSSARY BY MY PHYSICAL THERAPIST AND/OR PHYSICIAN. I AM AWARE THAT THE PRACTICE OF PHYSICAL THERAPY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF THESE SERVICES AT *COMPREHENSIVE PHYSICAL THERAPY.* IT IS THIS CLINIC'S SINCERE INTENT TO EDUCATE ME ON EVERY PROCESS, FROM BILLING TO TREATMENT AND EVENTUALLY DISCHARGE FROM SERVICES. THEREFORE, IF TECHNIQUES THAT ARE BEING USED TO RETRAIN, RECRUIT & RESTORE POSTURAL ALIGNMENT ARE NOT UNDERSTOOD, IT IS MY RESPONSIBILITY TO OBTAIN A CLEARER UNDERSTANDING OF WHAT THE THERAPIST'S OBJECTIVES AND OUTCOMES ARE, AND HOW HE/SHE IS TRYING TO ACHIEVE THEM. THIS CONSENT SHALL BE ON-GOING FOR A PERIOD NOT TO EXCEED ONE YEAR. DURING THE COURSE OF TREATMENT AT HORSEHEADS COMPREHENSIVE PT, YOUR THERAPIST MAY RECOMMEND A PROCEDURE, MATERIALS OR SUPPLIES WHICH MAY BE AN OUT-OF-POCKET EXPENSE. THESE WILL BE EXPLAINED TO YOU WITH THE UNDERSTANDING THAT YOU MAY REFUSE OR ACCEPT THEM. THESE OUT OF POCKET EXPENSES ARE EXPECTED AT THE TIME OF DISPENSING UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE REGARDING PAYMENT. THESE OUT OF POCKET EXPENSES MAY INCLUDE BUT ARE NOT LIMITED TO: INTOPHORESIS/ELECTRIC STIMULATION PADS, THERA-BAND/TUBING, SHOE ORTHOTICS AND LUMBAR BELTS. THESE MATERIALS AND SUPPLIES CAN ALSO BE BILLED TO YOUR INSURANCE COMPANY. IF PAYMENT IS RECEIVED FROM THE INSURANCE COMPANY, A REFUND WILL BE ISSUED TO THE PATIENT OR APPLIED TO ANY OUTSTANDING BALANCE.

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO *HORSEHEADS COMPREHENSIVE PHYSICAL THERAPY,* AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I UNDERSTAND THAT IF *COMPREHENSIVE PHYSICAL THERAPY* IS OUT OF NETWORK WITH MY INSURANCE COMPANY. I WILL BE RESPONSIBLE FOR THE DIFFERENCE BETWEEN WHAT IS CHARGED AND WHAT MY INSURANCE PAYS. I ALSO AUTHORIZE COMPREHENSIVE PHYSICAL THERAPY TO RELEASE ANY INFORMATION NECESSARY IN ORDER TO PROCESS MY CLAIM(S). ALL INFORMATION I HAVE PROVIDED IS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE. I AM RESPONSIBLE FOR ALL CHARGES INCURRRED AT *COMPREHENSIVE PHYSICAL THERAPY.*

I, _____ HAVE READ THIS FORM AND FULLY UNDERSTAND AND ACCEPT ITS TERMS AND CONDITIONS.

_____ DATE/TIME _____

IF NOT A PATIENT, STATE PATIENT NAME AND RELATIONSHIP TO PATIENT

Comprehensive Physical Therapy, Inc

A Restorative Physical Therapy Practice

Summary of Privacy Practices

This summary is provided to assist you in understanding our office's complete NOTICE OF PRIVACY PRACTICES

Our complete Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information which is located in our office.

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training students.

Uses and Disclosures Based on Your Authorization We will not use or disclose your health information without your written authorization, except as stated in more detail in the Notice of Privacy Practices.

Uses and Disclosures Not Requiring Your Authorization In the following circumstances, we may disclose your health information without your written authorization:

- For limited research and educational purposes
- For purposes of public health and safety
- To government agencies for purposes of their audits, investigations & other oversight activities
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas & as otherwise required by law

Patient Rights As our patient, you have the following rights:

- To have access to and/or a copy of your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notices of our privacy practices

If you have a question, concern or complaint regarding our privacy practices, please refer to our complete Notice of Privacy Practices.

Acknowledgement of Receipt of Privacy Practices Notice

Comprehensive Physical Therapy,Inc., Kathy Michaels, Office Administrator

I hereby acknowledge that I have received a copy of the *Comprehensive Physical Therapy* Notice of Privacy Practices.

I agree to be contacted via:

Signature: _____ **Cell phone:** _____

Print Name: _____ **Telephone:** _____

Date: _____ **E-mail:** _____

Authorization for the release and use of photograph and/or video to

The Physical Therapy Center of Horseheads

I authorize and permit the *Comprehensive Physical Therapy* to:

Photograph and/or video me while I am receiving physical therapy for the purpose of;

- ❖ Establishing a home exercise program, supplied to me via media outlet
- ❖ For limited research and educational purposes

My e-mail address is_____

_____ _____

Signature of Client (Parent/Guardian if under age 18) Today's Date

_____

Print Name of Client

2758 Westinghouse Rd., Horseheads NY 14901 / tel: (607) 795-1539/ fax: (607) 795-1918 / Email: comprehensivept2977@gmail.com