Integral Health Physical Therapy PC
Suite 207 C
125 High Rock Avenue
Saratoga Springs, NY 12866

(518) 450-7031
dr.katrinramsey@integralhealthphysicaltherapy.com

Dr. Katrin L Ramsey PT DSc CLT CAPP-OB

Doctor of Science in Orthopedic Physical Therapy

Certified Lymphatic Therapist

Certificate of Achievement in Obstetric Physical Therapy

Personal Information

Name: _____ Today's Date: _____

Age: _____ Date of birth: _____ Best number to reach you: _____

Street Address:_____

City:_____ State: _____ Zip: _____

Email address: _____

Biological Sex: _____ Gender identified with: _____

Preferred Pronouns:_____

Occupation: _____ Hours spent per week: _____

Do you enjoy your work?_____ Height:_____

Current Weight_____ 6 months ago_____ 1 year ago_____

Would you like your weight to be different? Y/N If so, ideal weight is _____

Marital Status: _____ Number/ages of children: _____

Do you have any pets? _____

Insurance Information:

Primary Care Physician: _____ Phone Nbr: _____

Insurance Carrier: _____ Member ID:_____

If insurance not self: Member Name: _____ Birthdate: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone Nbr: _____

How did you find out about Integral Health Physical Therapy?

_____

□ Please do not include me in any emails for special offers, clinic updates or announcements.

Patient signature - stating all information contained on this form is true:

Signature: _____ Date: _____

Health Issues/Concerns

List your main health problems and or concerns:

_____

_____

List your top 3 health promotion & wellness goals:

1) _____

2) _____

3) _____

Self Care:

Do you currently participate in exercise or mindfulness based activity?

(describe type, frequency and duration)

_____

_____

What are your main life stressors?

_____

_____

Do you have any obstacles preventing your optimal health goal achievement?

_____

How is your sleep?

_____

How is your hydration/nutrition?

_____

Who or what is your biggest support system right now?

_____

Are there any habits you have that you would like to discontinue?

_____

At what point in your life did you feel your best?

_____

Please list any healers, helpers, healthcare providers or therapies you are currently involved with:_____

_____

Current Medications/Supplements

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

_____

_____

Integral Health
Physical Therapy

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS (HIPAA Agreement)

Name: _____ **Birthdate:** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:
- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:

X_____ _____

Patient Signature or Legal Representative Date