PATIENT INFORMATION:

Name: _____ Sex: M / F Date of Birth: _____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____Cell: _____Work: _____

Emergency Contact: _____Relation:_____Phone:_____

E-Mail:_____ Doctor: _____

We are an environmentally conscious company; we try to save paper and your time by keeping these forms brief. If you would like a copy of any of the policies for your own records, just ask or look on our website (www.njptcoe.com).

Please *initial each space* below and *sign at the bottom* of the page acknowledging your agreement with each.

_____ I have received and read the **Privacy Notice**. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations as outlined in this agreement.

_____ I have received and read the **Fitness Center Waiver and Release**, and I am in agreement.

_____ I authorize payment to Physical Therapy Center of Excellence for all services rendered. I expect to be billed for these services if my insurance does not cover it, if I have not met my insurance deductible, and/or for my insurance plan's copayments and co-insurance.

_____ I affirm that the information provided on the patient history form is accurate to the best of my knowledge.

_____ I understand that cancellations and no-shows hinder the ability to accommodate the scheduling needs of all patients. If I am unable to notify the office of a cancellation **at least 24 hours prior to my scheduled appointment,** I understand I may be responsible for a **cancellation fee of $25.00.**

By signing below, I agree to conform with the above policies over the course of my treatment.

Patient or Parent Signature: _____ Date: _____

Confidential Medical and Social History

Occupation: _____Height: _____Weight: _____

Usual daily and recreational activities: _____

Injury date: _____How did your injury occur? _____

Surgery: _____Date: _____ Current complaints and limitations: _____

_____

Have you received prior treatment for this? PT / OT / Chiropractic / Acupuncture / Other: _____

**Some insurances may not pay for both PT and chiropractic care on the same day, check your benefits.*

Have you had any recent falls? Y / N If so, date(s):_____ Do you use: Alcohol / Tobacco / Drugs

Imaging: X-ray / MRI / CT scan / Ultrasound / Other: _____ Date(s):_____

Past Medical History: (please circle or mark all that apply)

High blood pressure	Osteoarthritis	Fibromyalgia
Heart disease / Angina	Kidney disease	Osteoporosis
Allergies / Asthma	Lung disease	HIV / AIDS
Rheumatoid arthritis	Liver disease	Diabetes
Unexplained weight loss	Cancer	Stroke
Increased pain at night	Seizures	Hepatitis
Mental illness	Ulcers	Depression
Latex allergy	Anxiety	Headaches

Other medical and surgical history: _____

_____

_____

Medications: _____

_____

Rate your pain from 0-10:
(0 = no pain and 10 = worst pain imaginable)

At Worst=_____/10

On Average_____/10

At Least=_____/10

Describe your pain:
Dull, Ache, Sharp, Stabbing, Numb,
Shooting, Tingling, Burning, Throbbing

Mark the pictures where you have pain*