



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 |

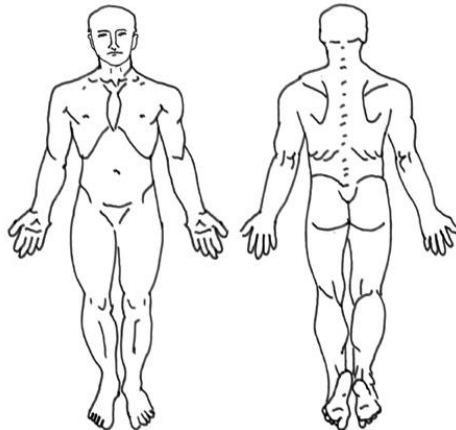
Other medical and surgical history: _____

Medications: _____

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

At Worst=_____/10
On Average_____/10
At Least=_____/10

****Mark the pictures where you have pain****



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