New Patient Information

Name ______________________________ **Date**________________

☐ Female ☐ Male Age:_____ Date of Birth: ____________ Height: ________ Weight:__________

Preferred Language: ☐ English ☐ Other __________

Race: ☐ White ☐ Hispanic ☐ African American ☐ Asian ☐ Other __________

Address:_____________________________ City ______________State_____Zip _________

Home Phone _________________________ Cell Phone ____________________________

Email Address ____________________________________ SS# ____________________

Preferred Method of Contact ____

Employer __________________ Occupation______________ Work Phone ________________

Emergency Contact ____________________Relation ______________ Phone ________________

How did you hear about our office? ____

Insurance Information:

Primary Insurance company name: ______________________ Member ID #: ______________________

Relationship to Insured (circle) SELF SPOUSE CHILD

Insured's Name: ______________________ Insured's DOB: ____________ Insured's Tel #: ______________

Secondary Insurance company name: ______________________ Member ID #: ______________________

Relationship to Insured (circle) SELF SPOUSE CHILD

Insured's Name: ______________________ Insured's DOB: ____________ Insured's Tel #: ______________

Chief Complaint? ____

Briefly describe how your problem began: ____

____

Is this a New Problem? ☐ Yes ☐ No

Did your problem begin:

☐ Immediately after a specific incident ☐ After multiple incidents ☐ Gradually developed over time

☐ No specific reason noted

What makes your problem BETTER?

☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Movement/Exercise ☐ Inactivity ☐ Nothing

☐ Hot ☐ Cold ☐ Other ____________________________

What makes your problem WORSE?

☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Movement/Exercise ☐ Inactivity ☐ Nothing

☐ Hot ☐ Cold ☐ Other ____________________________

How often are the complaints present?

☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

Since your problem began the pain has: ☐ Increased ☐ Decreased ☐ Not Changed

In addition to pain, do you experience: ☐ Radiating ☐ Numbness/Tingling

On a scale of 0-10, where would you rate your pain today? _______

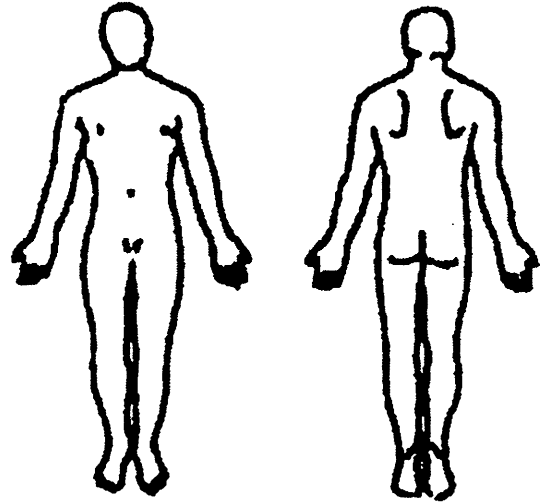
What treatment have you received for this present condition?

☐ No treatment ☐ Chiropractic ☐ Physical Therapy ☐ Acupuncture ☐ Injections

☐ Surgery ☐ Other: ____________________

Have you had chiropractic care before? ☐ Yes ☐ No

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity:

(1)____

(2)____

(3)____

Primary Care/MD:____________________________________

May we forward our findings to your doctor? ☐ Yes ☐ No

Current Medications: ______________________________

____

Allergies (Medicine, Food, Environment) ____________________

____

Previous Surgeries: ____

Hospitalizations/Operations: ____

Past Traumas/Accidents/Falls: ____

Do you have a PERSONAL history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke

Other serious illnesses ____

For Women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

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Family Medical History: To the best of your knowledge, has your mother, father, siblings, or grandparents ever had any of the following? ☐ Adopted/don't know

☐ High cholesterol
☐ Anxiety/panic attacks
☐ Arthritis
☐ Rheumatoid Arthritis
☐ Ulcerative colitis
☐ Alcoholism
☐ Obesity
☐ Thyroid disease
☐ Asthma
☐ Ankylosing Spondylitis
☐ Crohn's disease

☐ Kidney disease
☐ Osteoporosis
☐ Eczema
☐ Stroke
☐ Autoimmune disease
☐ Cancer
☐ Mental illness
☐ Allergies
☐ Gout
☐ Heart disease/Hypertension
☐ Lupus

☐ Depression
☐ Alzheimer's
☐ Diabetes
☐ Other serious illness (please list here): ________________

Health History & Assessment

Exercise: 0 1 2 3 4 5 6 7 days/week _______ minutes. ☐ Cardio ☐ Weight Lifting ☐ Yoga ☐ Other: ____________

What position do you sleep in: ☐ Side ☐ Stomach ☐ Back

How old is your mattress: _______ years What Type: ☐ Coil Spring ☐ Foam ☐ Water ☐ Air

What type of pillow do you sleep on: ☐ Foam ☐ Memory Foam ☐ Fiberfill ☐ Feather ☐ Other: ____________

Do you wear: ☐ Arch Supports ☐ Orthotics ☐ Heel Lifts

Do you take: ☐ Blood Thinners (Heparin, Coumadin, Warfarin) ☐ Steroids

Drink Alcohol: ☐ Yes ☐ No Use Tobacco: ☐ Yes ☐ No Use Recreational Drugs: ☐ Yes ☐ No

Please indicate if you have experienced any of the following conditions or symptoms:

General

- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ AIDS or HIV
- ☐ Fatigue
- ☐ Recent unexplained weight loss,
- ☐ Decreased energy
- ☐ Loss of appetite
- ☐ Night sweats
- ☐ Fever or chills
- ☐ Recurrent infections
- ☐ Skin ulcers or rashes
- ☐ Excessive thirst

Neuromusculoskeletal

- ☐ Stroke
- ☐ Paralysis
- ☐ Seizures
- ☐ Mental disorders
- ☐ Fractures
- ☐ Dislocations
- ☐ Orthopedic problems
- ☐ Arthritis
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Change in vision, smell, hearing or taste
- ☐ Light headedness
- ☐ Dizziness/vertigo
- ☐ Loss of consciousness
- ☐ Difficulty speaking or swallowing
- ☐ Headaches
- ☐ Numbness or tingling
- ☐ Difficulty walking
- ☐ Change in mood or behavior

Cardiovascular

- ☐ Pacemaker
- ☐ Defibrillator
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Irregular heart beat
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ TIA
- ☐ Peripheral vascular disease
- ☐ Blood clotting or bleeding disorder
- ☐ Anemia
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Nose bleeds
- ☐ Swollen ankles
- ☐ Redness or swelling of a limb,
- ☐ Unusual bruising
- ☐ Bleeding gums
- ☐ Swollen lymph nodes

Respiratory

- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ COPD
- ☐ Cough or change in cough
- ☐ Blood in sputum
- ☐ Wheezing
- ☐ Difficulty breathing

Digestive

- ☐ Liver disease
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Gall stones
- ☐ Appendicitis
- ☐ Pancreatitis
- ☐ Reflux disease
- ☐ Stomach pain
- ☐ Pain or difficulty swallowing,
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Excessive gas or belching
- ☐ Blood in stool
- ☐ Black stools

Genitourinary

- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Prostate enlargement
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Increased frequency of urination
- ☐ Difficulty with urination
- ☐ Loss of bladder or bowel control
- ☐ Change in menstrual bleeding

____ Initial here if none of the listed symptoms or conditions apply to you.

I have personally read and completed this form. Signature ______________________________

NOTICE OF PRIVACY PRACTICES

PATIENT NAME: ____

DATE: ______/______/________

THE NOTICE OF PRIVACY PRACTICES DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

GARDEN STATE PHYSICAL THERAPY GROUP is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations without facility. "Protected Health Information" and that information about you, including demographic information that may identify you and genetic information, and that relates to your past, present, and future physical or mental health condition related to health care services.

____

PRINT NAME

____

SIGNATURE OF PATIENT/HEALTH CARE AGENT/GUARDIAN

FINANCIAL AGREEMENT

Date: ____/____/_____

To Whom It May Concern:

By my signature below I am requesting that my doctor reduce my normal and customary fees charged so as to allow me to receive physical therapy care. My financial circumstances are such that if I were to pay the customary fees charged I would be forced (due to economic reasons) not to receive care.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in the office.

If my insurance company policy demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship I am only making partial payments.

Print Patient Name: ______________________________

Patient Signature: ______________________________

Witness Signature: ______________________________

BY SIGNING BELOW, YOU ARE IN AGREEANCE AND UNDERSTANDING THAT WE ARE AN ON OUT OF NETWORK PROVIDER. ANY CHECKS FROM YOUR INSURANCE COMPANY THAT BELONGS TO US MUST BE SIGNED AND GIVEN TO THE FRONT DESK.

PATIENTS WILL BE HELD 100% RESPONSIBLE FOR ALL CHECK AMOUNTS NOT GIVEN TO GARDEN STATE PHYSICAL THERAPY GROUP.

PATIENT SIGNATURE: ______________________________

DATE: ____________________