

Somerset Hills Physical Therapy

180 Mt. Airy Road, Basking Ridge, NJ 07920

REGISTRATION INFORMATION

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

Home Phone _____ Cell _____ Work _____

Address _____ City _____ Zip _____

E-mail _____ Marital Status: S M W D

Primary Medical Insurance Co. _____ ID# _____

Is patient the primary insured? Yes No

If no, please answer the following as related to billing and insurance:

Name of primary insured _____ DOB of primary insured _____

Relationship to patient _____ Address _____

Place of work where insurance was issued _____

Do you have secondary insurance? Yes No If yes, provide information below:

Secondary Insurance Co. _____ ID# _____

In case of emergency, who should be notified: _____ Phone _____

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO SOMERSET HILLS PHYSICAL THERAPY AND AUTHORIZE THE FILING OF INSURANCE AND RELEASE OF INFORMATION NECESSARY FOR COMPLETION OF CLAIMS. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES. _____ initial

I HAVE READ AND UNDERSTAND SOMERSET HILLS PHYSICAL THERAPY'S OFFICIAL PRIVACY POLICY REGARDING THE USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION. I AUTHORIZE SHPT TO RELEASE MY MEDICAL RECORDS TO THE FOLLOWING FRIEND OR FAMILY MEMBER: _____ initial

I HAVE READ AND AGREE TO SOMERSET HILLS PHYSICAL THERAPY'S PAYMENT AND CANCELLATION POLICIES. _____ initial

Signature of patient or responsible party _____

Date _____

Somerset Hills Physical Therapy, PC

REGISTRATION INFORMATION

So that we may process your insurance claims efficiently, please read and complete the following:

- Injury/Accident related to:
 Work School Motor Vehicle Other N/A
- Date of Injury/Accident (if applicable): ____/____/____
Claim# _____
- This incident may lead to legal action: Yes No
- Have you received Physical Therapy THIS YEAR prior to today's visit?
 Yes No
If yes: Facility _____ Diagnosis _____
Dates of Therapy _____ # of visits _____
- Where you discharged from a Hospital or Rehab Facility during the past 30 days? Yes No
If yes: Facility _____ Date of Discharge _____
- Have you received Home Care PT immediately prior to today's visit? Yes No
If yes: Name of agency _____ Number of visits _____
Date started _____ Date discharged _____
- Are you currently under the care of a Chiropractor? Yes No
- MEDICARE ONLY: Please initial here if you have been informed of the 2011 Medicare cap (\$1,870) on out-patient physical therapy: initials _____

Signature _____ Date _____

SOMERSET HILLS PHYSICAL THERAPY, PC

*Under Medicare and the NJ practice act we are required to obtain a complete medical history on all patients.
This information is protected under the HIPAA laws.*

Please answer all questions to the best of your ability to assist your physical therapist with your care.

Name _____ **Date of birth** _____

Height: ___ FT ___ IN **Weight:** ___ LB

Referring Doctor (name and address) _____

Internist or Family Doctor (name and address) _____

HISTORY OF PRESENT ILLNESS

1. **CHIEF COMPLAINT** (Why are you seeing the physical therapist today?) _____
2. How long have you had this problem? _____
3. What started the problem? _____

	yes	no	when?
4. Has the problem become worse?	___	___	_____
5. Is this problem the result of a car accident?	___	___	_____
6. Is this problem the result of a work accident?	___	___	_____
7. Have you missed any work because of this problem?	___	___	_____
8. Have you missed any school because of this problem?	___	___	_____

9. Signs associated with your chief complaint: *check all that apply* ___ **None Apply**

Sign	Location	Sign	Location
___ Swelling	_____	___ Drainage	_____
___ Redness	_____	___ Muscle atrophy	_____
___ Warmth	_____	___ Muscle spasm	_____
___ Edema	_____	___ Muscle twitching	_____
___ Skin changes	_____	___ Loss of movement	_____
___ Bruising	_____	___ Other	_____

10. Symptoms associated with your chief complaint: *check all that apply* ___ **None Apply**

- ___ Pain ___ Numbness or tingling
 ___ Weakness ___ Other _____

11. Is your chief complaint made worse by: *check all that apply* ___ None Apply

- ___ Sitting ___ Walking ___ Movement (what body part) _____
- ___ Standing ___ Going up stairs ___ Touch (what body part) _____
- ___ Laying down ___ Going down stairs ___ Other _____

12. Does anything make your chief complaint better? ___ Yes ___ No

If yes, please list: _____

13. Rate your pain severity using the following scale: My pain level is: (*circle a number*) ___ None Apply

- | | | | | | | | | | |
|------|--------|----------|---|--------|---|---------|---|--------------------|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| None | Slight | Moderate | | Severe | | Extreme | | Could not be worse | |

14. Describe the quality of your pain? *Check all that apply* : ___ None Apply

- ___ Sharp ___ Stabbing ___ Shooting ___ Other _____
- ___ Dull ___ Throbbing ___ Continuous ___ Other _____
- ___ Burning ___ Aching ___ Intermittant ___ Other _____

15. Treatments for your chief complaint have included: (*check all that apply*) ___ None Apply

- ___ Physical therapy; exercise ___ Manipulation ___ Anti-inflammatory medication ___ Pain medication
- ___ Massage and ultrasound ___ Tens unit ___ Traction ___ Braces
- ___ other (list) ___ other (list)

16. Medicines taken for your current problem:

How much?

How often?

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Write on the back of this form if more medications

17. Previous doctors seen for this problem: ___ None

Doctor	Specialty	location (city)	Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

18 Tests done to evaluate your problem: Check all that apply

None Apply

Test	Area Tested	Date	Test Location	Test	Area Tested	Date	Test Location
<input type="checkbox"/> Plain X-rays	_____	_____	_____	<input type="checkbox"/> Myelogram	_____	_____	_____
<input type="checkbox"/> Arthrogram	_____	_____	_____	<input type="checkbox"/> Bone Scan	_____	_____	_____
<input type="checkbox"/> MRI	_____	_____	_____	<input type="checkbox"/> EMG	_____	_____	_____
<input type="checkbox"/> CAT Scan	_____	_____	_____	<input type="checkbox"/> Other	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____	<input type="checkbox"/> Other	_____	_____	_____

Review of Systems: Check all that apply

None Apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Heart or chest pain | <input type="checkbox"/> Tooth problems |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Chest pain with breath | <input type="checkbox"/> Change in urine function |
| <input type="checkbox"/> Recent weight change | <input type="checkbox"/> Abnormal heart beat | <input type="checkbox"/> Difficulty urinating |
| <input type="checkbox"/> Very low energy | <input type="checkbox"/> Short of breath with walking | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Change of vision | <input type="checkbox"/> Short of breathe lying down | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Swollen ankles or feet | <input type="checkbox"/> Leaking urine |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Burning on urination |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Red or warm joints |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Green or yellow sputum | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Ear drainage | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Arm pain |
| <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Constipation | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Bad snoring | <input type="checkbox"/> Change in bowel function | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Change in voice | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Dark or tar looking stool | <input type="checkbox"/> Weakness of arms or legs |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Nervous exhaustion |
| <input type="checkbox"/> Swollen lymph glands | <input type="checkbox"/> Rashes | <input type="checkbox"/> Depression or anxiety |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Hives | <input type="checkbox"/> New moles or skin lesions |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Other |

Women only: I am pregnant **or may be pregnant**

Medical History: *Check all that apply*

- Heart attack
- Heart failure
- Angina (chest pain)
- High blood pressure
- Stroke
- Diabetes
- High cholesterol
- Rheumatoid arthritis
- Cancer of _____
- Osteoporosis
- Pneumonia
- Asthma
- Bronchitis
- Emphysema
- Lung disease
- Blood vessel disease
- Mental illness

None Apply

- Gout
- Ankylosing spondylitis
- Kidney stones
- Kidney failure
- Transplants
- Alcohol dependence
- AIDS
- Tuberculosis
- Other _____
- Hepatitis
- Lupus
- Blood clots in legs
- Blood clot in lungs
- Stomach ulcers
- Bleeding disorders
- Sickle Cell Disease
- Liver trouble

Surgical History: **None**

Operation	Surgeon	Location	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History : *Check all that apply* **None Apply**

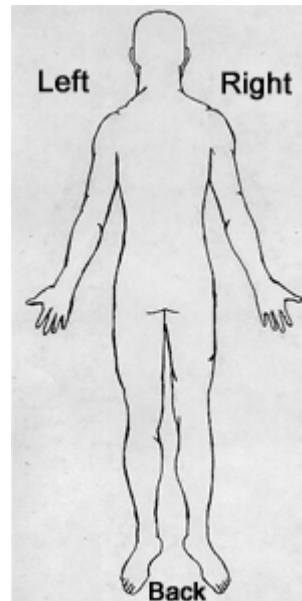
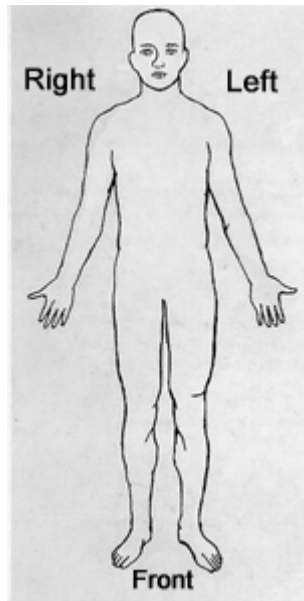
Condition	Which Family Member	Condition	Which Family Member
<input type="checkbox"/> Heart disease	_____	<input type="checkbox"/> Scoliosis	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Spine problems	_____
<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Kidney failure	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Mental illness	_____
<input type="checkbox"/> Osteoporosis	_____	<input type="checkbox"/> Bleeding disorders	_____
<input type="checkbox"/> Rheumatoid arthritis	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Osteoarthritis	_____	<input type="checkbox"/> Alcohol dependence	_____
<input type="checkbox"/> Lupus	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Sickle Cell	_____	<input type="checkbox"/> Other (list) _____	_____

Medications you take: **None**

Medication	Dose	How often	Reason for taking	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Shade in where you are having pain.

___ Does not Apply

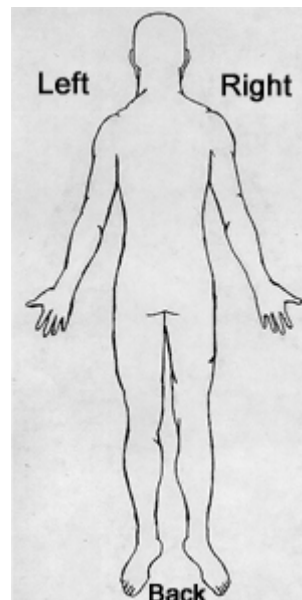
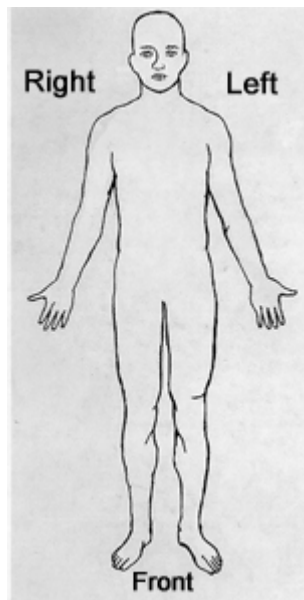


Draw the location of any other symptoms related to your problem. ___ Does not apply

Numbness / Tingling xxxxx

Weakness oooo

Other ++++ (list) _____



Allergies to Medications: *Check all that apply*

No Known Allergies

Medication	Rash	Wheezing	Swelling	Upset Stomach	Shock	Other (list)
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Social History: *Check all that apply*

Work Status

Occupation _____

Homemaker

Not working

Student

Working

Retired

Disabled

I Live: alone with _____

My signature confirms I have answered the above questions to the best of my ability.

Patient/Guardian Signature _____ Date _____

Note: *If you have any questions regarding filling out this form, please call us at: 908-766-1407*