

# SOMERSET HILLS PHYSICAL THERAPY

## REGISTRATION INFORMATION

Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell phone \_\_\_\_\_

Name \_\_\_\_\_ E-mail \_\_\_\_\_  
Last First Initial

Street address: \_\_\_\_\_

Town: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Female [ ] Male [ ] Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Driver's license #: \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_ Policy holder's SS #: \_\_\_\_\_

Single [ ] Married or Civil Union [ ] Domestic Partnership [ ]  
*Answer following if pertinent to insurance coverage:* Widow [ ] Legally Separated [ ] Divorced [ ]

Patient employed by: \_\_\_\_\_ Business address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business phone #: \_\_\_\_\_

Name of Responsible party and relationship to patient: \_\_\_\_\_

Spouse or responsible party employed by: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business phone #: \_\_\_\_\_

Medical Insurance company \_\_\_\_\_ ID # \_\_\_\_\_

Is patient the primary insured? Yes [ ] No [ ] ***If no please answer the following as required by insurance for billing and coverage.***

Name of primary insured? \_\_\_\_\_ Birth date of primary insured \_\_\_\_\_

Address of primary insured \_\_\_\_\_

Place of work where insurance was issued \_\_\_\_\_

Do you have secondary insurance? No [ ] Yes [ ] If yes, give information below:

Secondary medical Insurance company \_\_\_\_\_ ID # \_\_\_\_\_

In case of emergency, who should be notified: \_\_\_\_\_ Phone #: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

\_\_\_\_\_  
Signature of patient

(Or, responsible party if patient is a minor or unable to sign) 8/07

# 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**

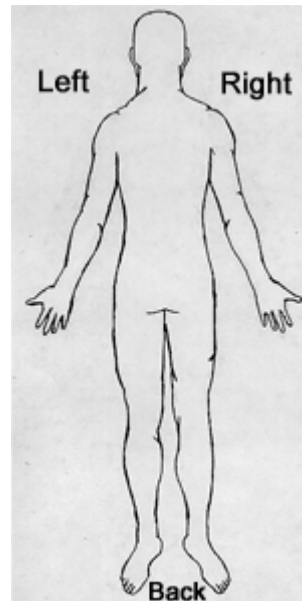
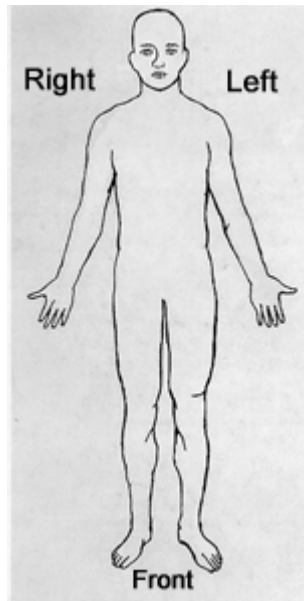
Condition	Which Family Member	Condition	Which Family Member
<input type="checkbox"/> Heart disease	_____	<input type="checkbox"/> Scoliosis	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Spine problems	_____
<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> 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

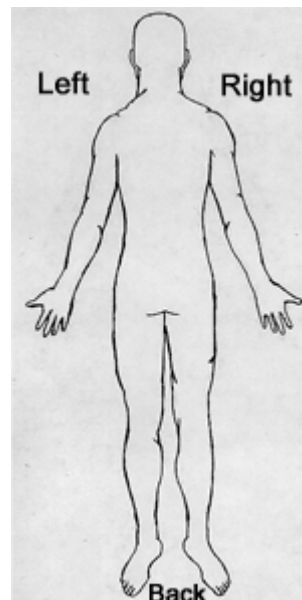
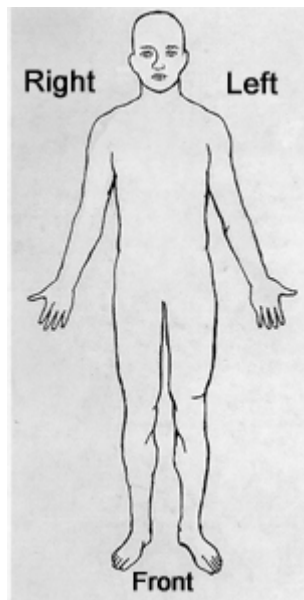


Draw the location of any other symptoms related to your problem. \_\_\_ Does not apply

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*