Somerset Hills Physical Therapy, PC
180 Mount Airy Road, Suite 103
Basking Ridge, NJ 07920
Phone (908) 766-1407
Fax (908) 953-8454

www.somersethillspt.com

Patient Information:

Name _____ Sex M F Date of Birth _____

Address_____ City _____ State_____ Zip_____

Home Phone _____ Cell _____ Work _____

E-Mail _____ (For SHPT use only)

Emergency Contact _____ Phone _____

Insurance Information (You may skip this section if we have copied your card)

Primary Medical Insurance Co. _____ ID# _____

Is patient the primary insured? Yes No If "No" please complete the following:

Name of Primary Insured _____

Date of Birth of Primary Insured _____

Relationship to Patient _____

Secondary Insurance? Yes No Company _____ ID_____

Injury Information

Are you currently under the care of a Chiropractor? _____
Your insurance policy may not cover both PT and Chiropractic care on the same day.

Was this injury sustained at Work? Yes No
Was this injury a result of a Car Accident? Yes No

If you answered yes, please provide:
Name of Insurance Company _____
Date of Accident _____ Claim # _____

Have you received ANY physical therapy this year? Yes No

Somerset Hills PHYSICAL THERAPY
Orthopaedics & Sports Medicine

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info@somersethillspt.com
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I authorize payment to Somerset Hills Physical Therapy, PC for all physical therapy services rendered. I will expect to be billed if I have not met my **deductible** and/or for **coinsurance** balances as information is received to SHPT. **Co payments** are due at time of service.

Patient Signature/Parental Signature for Minor Date

I consent my release of information and/or disclosure to Somerset Hills Physical Therapy, PC of my medical record and forms to other health care providers involved in my care or third party payers as is necessary for processing claims.

Patient Signature/Parental Signature for Minor Date

I understand that Somerset Hills Physical Therapy, PC requires 24 hours notice if I need to cancel my appointment. I will expect to be billed $35.00 for each appointment when 24 hours is not given. (908) 766-1407 info@somersethillspt.com

Patient Signature/Parental Signature for Minor Date

I have read the Somerset Hills Physical Therapy, PC HIPAA Notice of Privacy Practices.

Patient Signature/Parental Signature for Minor 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-inflammatorymedication ___ 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
___ Plain X-rays	_____	____	_____	___ Myelogram	_____	____	_____
___ Arthrogram	_____	____	_____	___ Bone Scan	_____	____	_____
___ MRI	_____	____	_____	___ EMG	_____	____	_____
___ CAT Scan	_____	____	_____	___ Other	_____	____	_____
___ Other	_____	____	_____	___ Other	_____	____	_____

Review of Systems: *Check all that apply* ___ **None Apply**

___ Fever
___ Chills
___ Recent weight change
___ Very low energy
___ Change of vision
___ Blurry vision
___ Double vision
___ Itchy eyes
___ Frequent headaches
___ Loss of hearing
___ Ear pain
___ Ear drainage
___ Ringing in ears
___ Frequent nose bleeds
___ Bad snoring
___ Sore throat
___ Change in voice
___ Difficulty swallowing
___ Easy bruising
___ Easy bleeding
___ Swollen lymph glands
___ Sinus infections
___ Dizziness

___ Heart or chest pain
___ Chest pain with breath
___ Abnormal heart beat
___ Short of breath with walking
___ Short of breathe lying down
___ Swollen ankles or feet
___ Poor circulation
___ Persistent cough
___ Wheezing
___ Green or yellow sputum
___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Change in bowel function
___ Stomach pain
___ Blood in stool
___ Dark or tar looking stool
___Ulcers
___ Frequent infections
___ Rashes
___ Hives
___ Gum problems

___ Tooth problems
___ Change in urine function
___ Difficulty urinating
___ Frequent urination
___ Blood in urine
___ Leaking urine
___ Burning on urination
___ Swollen Joints
___ Red or warm joints
___ Broken bones
___ Neck pain
___ Back pain
___ Arm pain
___ Leg pain
___ Seizures
___ Blackouts
___ Loss of memory
___ Weakness of arms or legs
___ Poor balance
___ Nervous exhaustion
___ Depression or anxiety
___ New moles or skin lesions
___ Other

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

Medical History: *Check all that apply* ___**None 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

___ 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

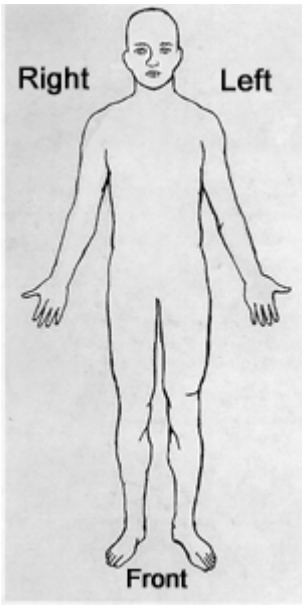
Family History : *Check all that apply* ___ **None Apply**

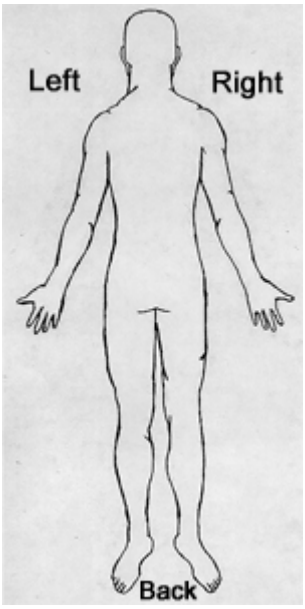
Condition	Which Family Member	Condition	Which Family Member
___ Heart disease	_____	___ Scoliosis	_____
___ Stroke	_____	___ Spine problems	_____
___ High blood pressure	_____	___ Kidney failure	_____
___ Diabetes	_____	___ Mental illness	_____
___ Osteoporosis	_____	___ Bleeding disorders	_____
___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

Medications you take: ___**None**

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

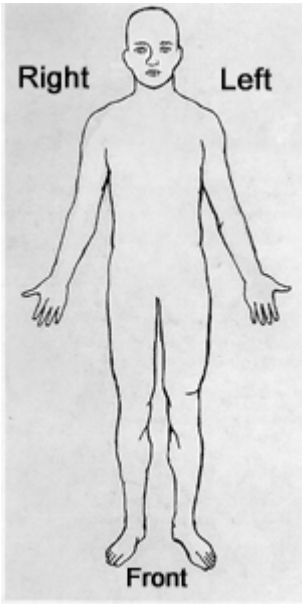
Shade in where you are having pain. **____Does not Apply**

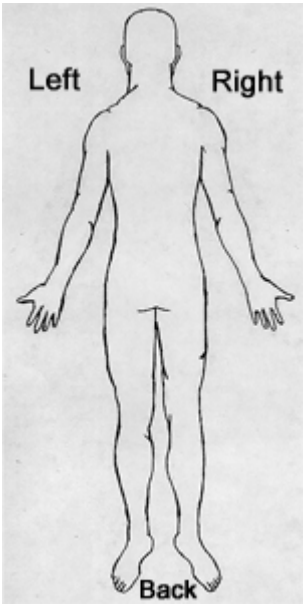




Draw the location of any other symptoms related to your problem. **___Does not apply**

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