Spectrum Therapeutics of New Jersey

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PLEASE FILL OUT THIS SHEET COMPLETELY AND CORRECTLY.
PLEASE PROVIDE ALL INSURANCE CARDS TO THE RECEPTIONIST TO COPY.
THANK YOU!

Name:________________________________ Social Security #:______________________

Date of Birth:_______________ Sex: Male [__] Female [__] Marital Status:______________

Address: ______________________________ City, State, & Zip Code: __________________

Contact Information:

Home #:______________ Cell #:_______________ Cell Phone Carrier:__________________

Work#: _______________ Ext:________________ Email: __________________________

How did you first hear about us? (Add name if Patient Referral or Physician)

Website Facebook Brochure Patient Referral:_____________ Physician:_______________

In the event of an emergency, who should we contact?

Name:_____________________________ Primary Phone #:____________________

Relationship:________________________ Secondary Phone#:___________________

Insurance Information:

Primary Insurance Co.:_____________________ ID:__________________ Group #:________

Secondary Insurance Co.:___________________ ID:__________________ Group #:________

If you are covered by someone else's insurance, what is the relationship?

Spouse: [__] Parent: [__] Guardian: [__] Employer: [__]

Their Name/ Employer: _______________________________ Sex: Male [__] Female [__

Their Date of Birth: _______________________ Their SS#:______________________

Address:______________________________ City, State, & Zip: __________________

I authorize the release of any information including medical records, diagnosis and treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay Spectrum Therapeutics of New Jersey. I understand that I am fully responsible for all non-covered services as well as any balances not paid by my insurance carrier. I will agree to abide by all policies and procedures as set for the physical therapist and my insurance carrier, failure to do this will result in dismissal from this medical practice.

Signature of Patient or Guardian: ______________________________ **Date**:__________

PLEASE FILL OUT THIS FORM AS COMPLETE AS POSSIBLE. IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION WILL REMAIN CONFIDENTIAL UNLESS AUTHORIZED FOR RELEASE BY THE PATIENT.

NAME: ____ AGE: _________ WEIGHT:________ HEIGHT:_________

OCCUPATION: ___________________________________ HOBBIES: _____________________________________

DATE OF INJURY: ____________________ PLEASE CIRCLE: SUDDEN ONSET GRADUAL ONSET

HAS THIS INJURY PREVENTED YOU FROM WORKING? [__] Y [__] N IF YES, HOW LONG OFF WORK __________

WORK STATUS:

AT THE **PRESENT TIME I** AM ABLE TO:

________ Work without restrictions
________ Work the same job with restrictions
________ Work a different job with restrictions
________ Unable to work due to dysfunction
________ Don't normally work outside the home
________ Homemaker
________ Retired
________ Other:____________________________

IS AN ATTORNEY INVOLVED WITH THE CASE? [___] YES [___] NO
IF YES, ATTORNEY NAME:____ PHONE:________________________

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

_______ No other treatment
_______ Physical/Occupational Therapy
________ Massage Therapy
________ Psychiatrist/Psychologist
_______ Chiropractor
_______ Other: ________________

LIST ALL CURRENT **PRESCRIPTION** MEDICATION W/ DOSAGE (Including injection and skin patches):

____

____

____

LIST ALL CURRENT **OVER-THE-COUNTER** MEDICATIONS W/ DOSAGE (Including vitamins and supplements):

____

____

____

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	SURGERY/HOSPITALIZATION	REASON
__________	_____________________________________	____
__________	_____________________________________	____
__________	_____________________________________	____

ARE YOU CURRENTLY HAVING OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS IN THE PAST 3 MONTHS?

_____ Fever
_____ Pins/Needles
_____ Vision Problems
_____ Chills
_____ Numbness
_____ Hearing Loss
_____ Night Sweats
_____ Skin Rash
_____ Bowel/Bladder Problem
_____ Shortness of Breath
_____ Headaches

PLEASE CHECK ALL THE FOLLOWING CONDITIONS THAT APPLY TO YOU EITHER PRESENTLY OR IN THE PAST

_______ High Blood Pressure
_______ Chest Pain/Heart Attack
_______ Stroke
_______ Heart Disease
_______ Cardiovascular Disease
_______ Emotional/Psychological Problems
_______ Epilepsy/Seizures
_______ Kidney Disease
_______ Asthma
_______ Emphysema/Bronchitis
_______ Hearing Loss
_______ Gout
_______ Hepatitis
_______ Arthritis
_______ Tuberculosis
_______ Thyroid Problems
_______ Chemical Dependency (alcohol/drugs)
_______ Varicose Veins
_______ Dizziness/Fainting
_______ Depression
_______ Lung Disease

_______ Allergies:____

_______ Other:____

HAS ANYONE IN YOUR IMMEDIATE FAMILY (Parents, Brothers, Sisters) EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

_______ Cancer
_______ Arthritis
_______ Heart Disease
_______ High Blood Pressure
_______ Diabetes
_______ Kidney Disease
_______ Tuberculosis
_______ Mental Disorder
_______ Stroke

HAVE YOU RECENTLY EXPERIENCED ANY SIGNIFICANT CHANGES IN:

_______ Mood
_______ Interest or pleasure in daily activities
_______ Loss/Gain of appetite or weight loss/gain
_______ Energy level (restlessness, lethargy, or fatigue)
_______ Recurrent thoughts of death or harming yourself
_______ Sleeping habits

How many packs of cigarettes do you smoke per day? ____________________________

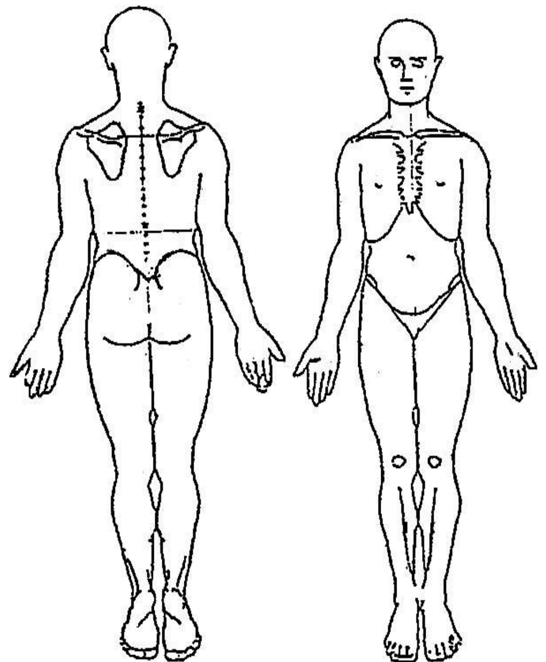
How many days per week do you drink alcohol? _________ How much do you drink at an average sitting? ____________

Are there any other substances that you regularly use? ____________________________

ARE YOU AWARE OF YOUR CURRENT DIAGNOSIS? [___] YES [___] NO

DO YOU HAVE QUESTIONS REGARDING YOUR
DIAGNOSIS OR PROGNOSIS [___] YES [___] NO

PLEASE MAP YOUR AREAS OF DISCOMFORT OR ALTERED SENSATION ON THE BODY MAP:
XXX = Pain 000 = Numb/Tingle *** = Weakness



OTHER COMMENTS OR CONCERNS YOU MAY HAVE:

____

____

____

Form reviewed by therapist:
__________ (PT initials) Date: ______________

Spectrum Therapeutics of New Jersey

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

PATIENT ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (“PHI”) about you. By signing this receipt, you acknowledge that you have reviewed, or been given the opportunity to review, our Notice of Privacy Practice. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting Spectrum Therapeutics of NJ, LLC.

You have the right to request how your PHI is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by this agreement.

______________________________ ______________________________

Patient Name Patient Signature

______________________________ ______________________________

Name of Witness Witness Signature

____

Date