North Jersey Physical Therapy Medical History Questionnaire

Today's Date:_____

Name: _____Date of Birth:_____ Age:_____

Occupation: _____Currently working ?: _____

How did you hear about our practice:_____

Referring Physician (full name & office location):_____
_____

Primary Care Physician (full name & office location:_____
_____

Reason for your appointment/diagnosis:_____
_____

Date of Onset/Cause:_____

Have you had previous episodes of this condition?: Yes No
Date of previous episode:_____

Today my level of pain is: 0 1 2 3 4 5 6 7 8 9 10
(circle one number) least worst

Have you received physical therapy for this condition prior to today? Was it helpful?
_____

What other treatments have you received for this condition? Were they helpful?
_____

Besides pain, do you have numbness? Yes No
Tingling? Yes No
Weakness? Yes No
Where:_____

Current medications: _____
_____

Circle tests you have had to diagnose this condition: X-ray MRI CAT scan
EMG Other
Results:_____
_____

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Name:_____Date:_____

What activities worsen the pain?

_____

What decreases the pain?

_____

Are you getting: better worse staying the same (circle one)

_____

How close to full normal function are you now?

0% 25% 50% 75% 100%

What are your goals for physical therapy?_____

_____

Please indicate any of the following conditions you currently have with the letter"C" and those you have had in the past with the letter "P" indicating the date.

Asthma _____
AIDS _____
Angina _____
Arthritis _____
Bladder/Bowel Disorder _____
Cancer _____
Cardiac Condition _____
Chronic Infection _____
Diabetes _____
Hepatitis _____
Other _____

High Blood Pressure _____
Hypoglycemia _____
Low Blood Pressure _____
Lyme's Disease _____
Migraine Headaches _____
Polio _____
Respiratory Condition _____
Seizure Disorder _____
Sleep Disorder _____
Thyroid Condition _____
Tuberculosis _____

Surgeries(please include procedure and date);

_____

Fractures(please include procedure and date):

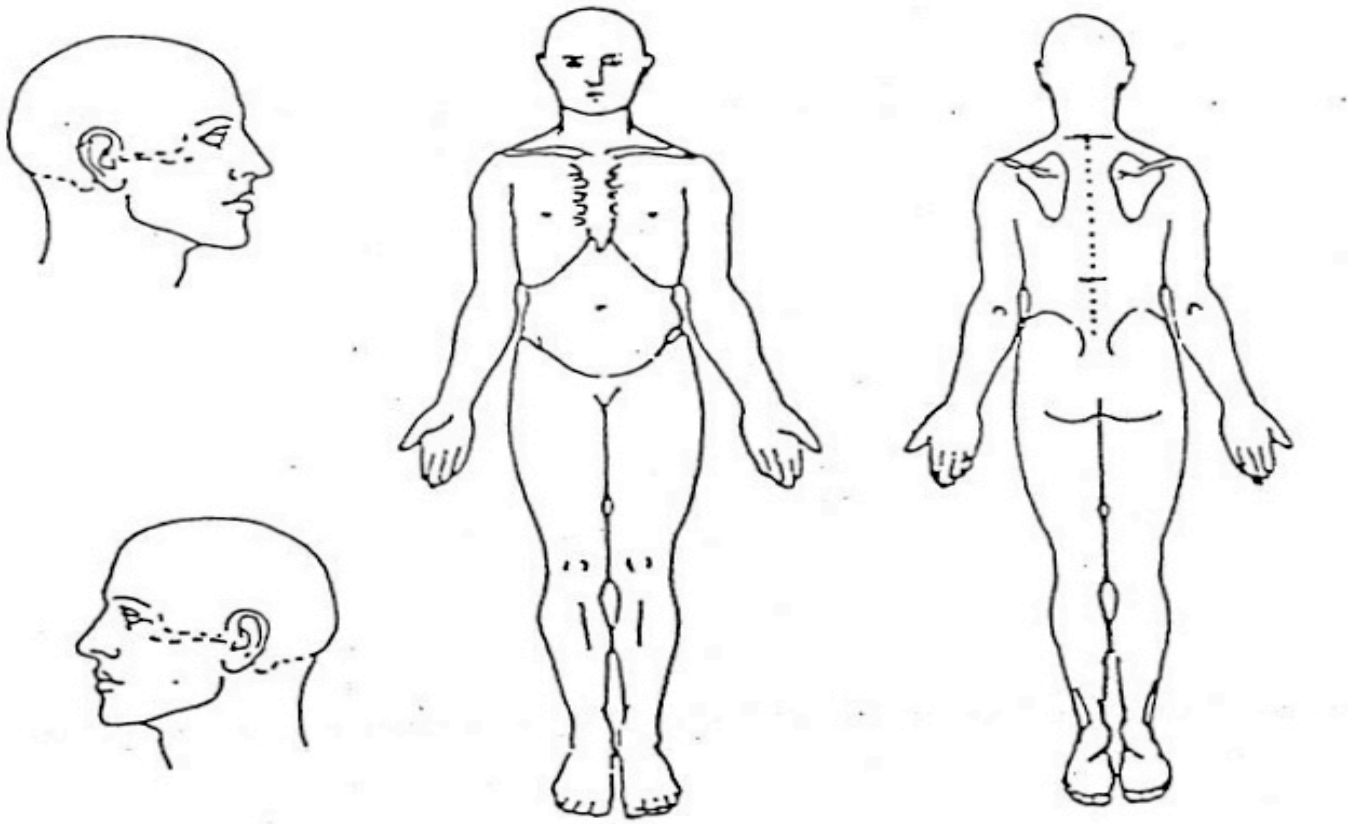
_____

North Jersey Physical Therapy
Numeric Pain Rating Scale and Body Diagram

Name:_____ Date:_____

Please mark the figure below by using the following symbols to indicate where your pain is and what kind of pain you are having.

Burning: xxxxx Stabbing: >>>>> Aching/Throbbing: ooooo Numbness/Tingling: ///////



Please let us know how severe your pain is with "0" being no pain at all while "10" is the worst pain imaginable. Circle the one number that most closely indicates your pain level.

Rate your **pain at this moment** (circle only one number):

no pain										worst pain
0	1	2	3	4	5	6	7	8	9	10

Rate the **least amount of pain** you have had **in the past 24 hours** (circle only one number)

no pain										worst pain
0	1	2	3	4	5	6	7	8	9	10

Rate the **most amount of pain** you have had **in the past 24 hours** (circle one number)

no pain										worst pain
0	1	2	3	4	5	6	7	8	9	10

North Jersey Physical Therapy
Patient - Specific Functional Scale

Name:_____ Today's Date_____

Identify up to 5 important activities that you are unable to do or are having moderate to extreme difficulty doing as a result of your pain. For each activity, rate the level of difficulty you have performing each activity using the 0-10 scale listed below. The higher the number, the more easily you can perform the activity. The lower the number, the more difficulty you have.

Once you have included activities you are unable to do or are having moderate to extreme difficulty doing, you may also include activities that your are having just a little bit of difficulty doing. Only include these activities if you have not already listed 5 activities you have moderate to extreme difficulty doing.

Note: If you are filling this form out at a follow-up appointment, be sure to rate the same activities you listed at your initial appointment. Ask your therapist for a copy of your initial form so that you can rate the same activities.

Rating Scale:

0 = unable to perform the activity **10 = able to perform activity at the same level as before**

0 1 2 3 4 5 6 7 8 9 10

Activity	**1st Visit**		
1.			
2.			
3.			
4.			
5.			
Avg Score			

Examples: Prolonged sitting/standing, Bending over, Lifting and Carrying, Pushing and Pulling, reaching overhead, Looking up/down, Turning head side to side, Walking time or distance, Running time or distance, Sleeping positions, Walking up/down steps, Reading, Driving, Kneeling, Squatting, Grasping, Chewing, Swallowing, Breathing

North Jersey Physical Therapy Associates, Inc.

www.northjerseypt.com
490 Schooley's Mountain Rd, Ste. 3B, Hackettstown, NJ 07840
Phone 908-852-7575; Fax 908-852-9083
95 Madison Ave, Ste 109A, Morristown, NJ 07960
Phone 973-538-8877; Fax 973-538-8873

Assignment of Benefits, Authorizations and Right to Privacy

Assignment of Benefits

I authorize payment of insurance benefits be made directly to North Jersey Physical Therapy Associates, Inc (NJPTA) for any services rendered to me and/or my dependents by NJPTA.

Authorized Representative

I hereby appoint NJPTA as my authorized representative with the power to (1) file medical claims with my health plan (2) file reconsiderations, appeals and grievances with my health plan (3) discuss or divulge any of my personal health information or that of my dependents with my health plan.

Authorization to Release Information/Consent to Use and Disclose Health Information

I understand that this practice maintains health records describing the health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care regarding myself or my dependents. I understand that this information will be used for the purposes of treatment, payment and healthcare operations. Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. Payment includes the disclosure of health information to your insurance company or its administrator so payment can be obtained for services rendered. Health Care Operations include utilization of your records to monitor quality of care given at this practice. I authorize the release of any medical or other information necessary for the purposes stated above.

Notice of Privacy Practices

I have a right to review or request a copy of the N*otice of Privacy Practices* that provides a more complete description of information uses and disclosures prior to signing this consent. A copy may be obtained in one of the NJPTA office locations or on their website. I have the right to object to the use of my health information for directory purposes. I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Name of Patient (Print): _____

Signature of Patient or Parent/Guardian:_____ Date_____

Relationship to Patient:_____

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Patient Responsibility

Financial Responsibility

I understand that I am financially responsible to this organization for any charges not covered by my health insurance plan. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for professional services received. All deductible payments, co-pays, estimated co-insurance payments, self-pay payments, late cancellation fees, no show fees, and payments for supplies are expected to be paid at the front desk. Out of network insurance payments that are sent directly to you must be brought to the office or mailed to the billing office in Hackettstown within 15 days of receiving the check(s) along with copies of the statements so that we know how to allocate the payments.

Missed Appointments and Our Cancellation and No Show Policy

We consider it an honor and privilege to be of service to you. In order to maximize the benefit of your treatment, our physical therapy staff provides one-on-one care during treatment sessions reserved especially for you. We do not double book. Missing appointments will impede your progress. Make every effort to attend every scheduled visit according to the treatment plan recommended by your therapist and doctor.

You are responsible for your schedule. Make a habit of double-checking your next visit. Note changes to your schedule right away. Not showing up for your appointment or appointments cancelled less than 24 hours in advance affect us all. Available appointments are in high demand and your early cancellation will give another person the possibility to have the treatment they need.

Due to decreases in in-network health insurance payments, rising costs including dry needling costs which are currently administered for free (Most insurances do not pay for dry needling.), increased paperwork and statistics reporting required by insurances, and a rising demand for our specialties have forced us to implement a harsher late cancellation and no show fee of $60.00 per missed visit beginning January 1, 2015.

Although we do understand that there may be extenuating circumstances, cancellations less than 24 hours or not showing up for your appointment for any reason will result in a $60.00 fee beginning January 1, 2015

Name of Patient (print): _____

Signature of Patient or Parent/Guardian:_____ Date_____
Relationship to Patient:_____