

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.

Name _____ Birthday _____ Sex M F

Address _____ City _____ Zip _____

Home # _____ Cell # _____ Cell Provider for Reminders _____

Marital Status: M S D W Children, Ages _____ Soc. Sec # _____

Email _____ May we send information here? Yes No

Occupation _____ Employer _____ Work Phone _____

Insured's Name _____ Birthday _____ Relation to Insured? _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

When did the condition begin? _____

What do you think caused this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: Improved Unchanged Getting Worse

Is this condition interfering with your: Work Sleep Daily Routine Other _____

Other doctors or therapists who have treated THIS condition: _____

List surgical operations and years: _____

Do you have a family physician? Name _____

May we contact your physician regarding your care? _____

Medications, dosage and frequency: _____

Have you been in an auto accident or had any other personal injury? Y N Describe _____

ADVANCED HEALTH & PHYSICAL THERAPY SOLUTIONS

FAMILY HISTORY: (Indicate whether, mother, father, brother/sister, or grandmother/grandfather, and age of onset if known)

Heart disease: _____ High blood pressure: _____ Stroke: _____

Diabetes: _____ Cancer: _____ Psychological: _____

Arthritis: _____ Osteoporosis: _____ Other: _____

SOCIAL HISTORY: (Check the boxes and fill in)

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work Heavy Moderate Light Hours Per day _____

Physical Work Heavy Moderate Light Hours Per day _____

Exercise Heavy Moderate Light Hours Per week _____ Type _____

Smoking Current Previous Pack/Day _____ No. of years _____

Alcohol Beer Liquor Wine Servings/Week _____ No. of years _____

MARK YOUR AREAS OF YOUR SYMPTOMS ON THE FIGURE BELOW.

Use the following symbols:

Aches Numbness Pins/Needles +++++ Stabbing **////**

MARK AN "X" ON THE LINES:

How bad are your symptoms now?

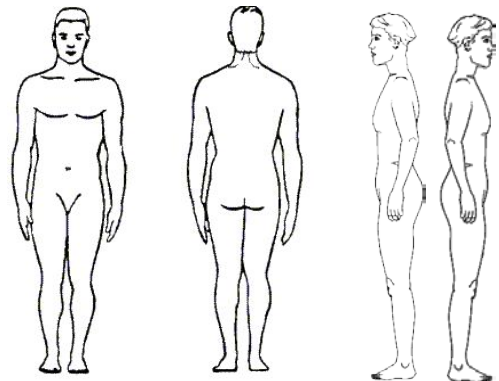
Severity:
Least Pain 1 _____ 10 Most Pain

How bad have they been in the past?

Severity:
Least Pain 1 _____ 10 Most Pain

Frequency:

- Occasional 0-25% Intermittent 26-50%
 Frequent 51-75% Constant 76-100%



NOTES: _____

Please review the following statements and indicate consent by signing below.

*I authorize the release of any medical information necessary to process my claim.

*I authorize payment of medical and surgical benefits to: Advanced Health & Physical Therapy Solutions

*I have received a copy of the Hunterdon Advanced Health & Physical Therapy Solutions Financial Policy.

*I have received a copy of the practice HIPAA policy.

Signature _____ Date _____

Parent/Guardian _____ Date _____