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 _____

_____

40 MORRISTOWN ROAD · SUITE 1B · BERNARDSVILLE, NJ · 07924
PHONE (908) 766-5663 · FAX (908) 766-7768
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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 ___

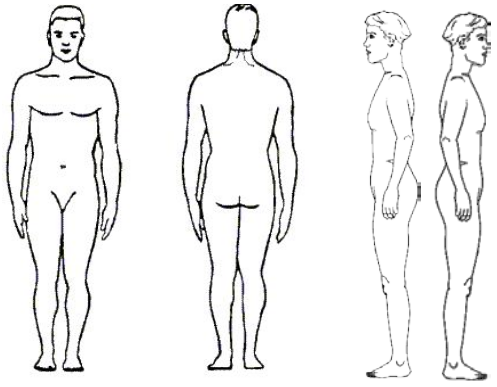
MARK YOUR AREAS OF YOUR SYMPTOMS ON THE FIGURE BELOW.
Use the following symbols:

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 _____

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