

REGIONAL PHYSICAL THERAPY
586 KEARNY AVENUE, 2 FL., KEARNY, NJ, 07032
Tel. 201.991.9272. Fax 201.991.1532 www.regionalpt.net

PATIENT INFORMATION			EMAIL ADDRESS: _____		
First Name:	Last Name:	Middle Initial:	Date: / /		
Address:		City:	State:	Zip:	
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -		
Home Phone: () -	Alternative Phone (Cell, Pager): () -		Spouse:		
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend					
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:					
WORK INFORMATION					
Employer:			Work Phone () -	Ext.	
Occupation:	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed				
CARE PROVIDER INFORMATION					
Referring Dr:			Referring Dr. Phone: () -		
Regular Dr./PCP			Regular Dr./PCP Phone: () -		
INSURANCE INFORMATION			(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)		
Primary Insurance Name:					
Subscriber's Name (If different):				Birth date: / /	
ID. #:	Group/Policy #				
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of Secondary Insurance:					
Subscriber's Name:				Birth date: / /	
ID. #:	Group/Policy #				
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
AUTO OR WORK INJURY CLAIM			(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)		
Insurance Name: <input type="checkbox"/> Auto :		<input type="checkbox"/> Labor & Industries:			
Adjuster/Claim Manager:			Phone:	Ext.:	
Address:		City:	State:	Zip:	
Claim #:	Accident Date: / /		Cause:		
ATTORNEY INFORMATION					
Name:		Law Firm:	Phone: () -		
Address		City:	State:	Zip:	
IN CASE OF EMERGENCY					
Name of Local Friend or Relative (Not Living at Same Address):					
Relationship to Patient:		Home Phone: () -	Work Phone: () -		

I authorize my insurance benefits be paid directly to Regional Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Regional Physical Therapy to release any information required to process my claims.

Signature of Patient, Parent, Guardian, Personal Representative

Date

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

LUNGS					
	YES	NO			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>			

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			
What types of exercise do you perform? : _____				
What things cause stress in your life? : _____				

Are you taking any seizure medication? YES NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?
 YES NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? YES NO What week?: _____

Have you had any injuries related to work? YES NO If yes list body part and date.: _____

Have you had any Auto Accidents YES NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? YES NO Where: _____

Signature of Patient, Parent, Guardian, Personal Representative

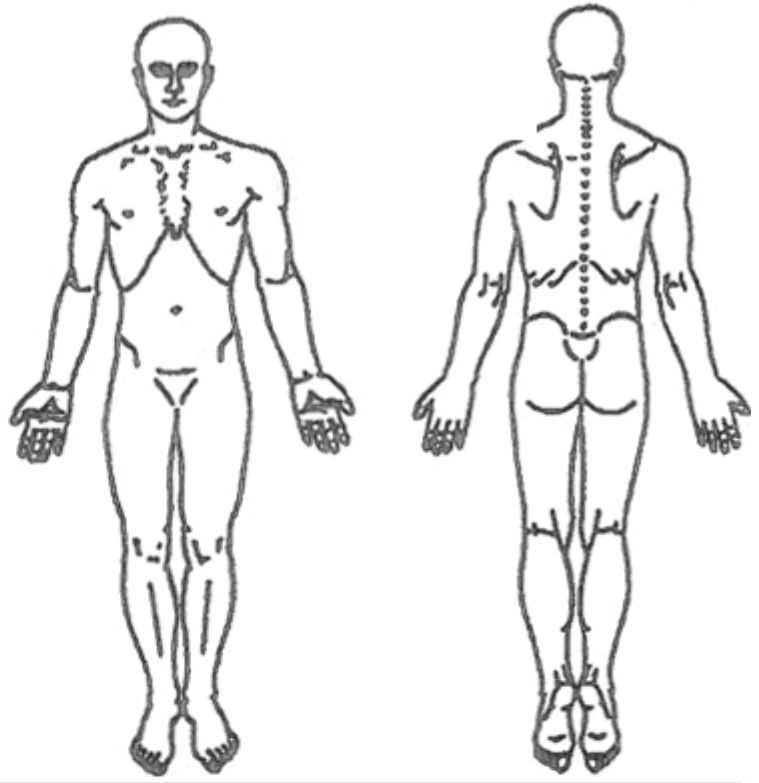
Date

Pain and Symptom Status Report

Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



- | | | |
|---|-----------------------------|--------------------------------|
| Ache
MMM
M | Burning

-- | Numbness
OOOO
OOO |
| Pins and Needles
□□□□□□□□
□□□□□□□□ | Stabbing
///// | Other
xxxx
xxx |

Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your **CURRENT** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your **AVERAGE** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your **WORST** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Additional Comments _____

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Dear Patient,

You recently received physical therapy services at our facility. Because we strive to deliver the best possible physical therapy services, we are interested in learning from our patients how we might improve or enhance our services. Please take a few minutes to complete and return this questionnaire.

Please place a check mark in the appropriate box to indicate your rating, or answer the descriptive questions on the appropriate line. Any additional comments you or testimonials you wish to make are welcome. Please return the questionnaire to us at your earliest convenience.

Thank you very much for your feedback!

Descriptive Questions

1. How did you learn about this facility? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Insurance company recommendation |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Former patient |
| <input type="checkbox"/> Telephone book | <input type="checkbox"/> Other, please indicate _____ |

2. Was this your first experience with physical therapy? Yes No

3. Was this your first experience at this facility? Yes No

Please rate your degree of satisfaction with each of the following statements.

(1= strongly disagree, 2= disagree, 3= neither agree nor disagree, 4=agree, 5= strongly agree; please circle N/A if you have no option on the subject)

	Circle one					
4. My physical therapist was courteous.	1	2	3	4	5	N/A
5. All other staff members were courteous.	1	2	3	4	5	N/A
6. The clinic scheduled appointments at convenient times.	1	2	3	4	5	N/A
7. I was satisfied with the treatment provided by my physical therapist.	1	2	3	4	5	N/A
8. My first visit for physical therapy was scheduled quickly.	1	2	3	4	5	N/A
9. It was easy to schedule visits after my first appointment.	1	2	3	4	5	N/A
10. I was seen promptly when I arrived for treatment.	1	2	3	4	5	N/A
11. The location of the facility was convenient for me.	1	2	3	4	5	N/A
12. I was satisfied with the overall quality of my physical therapy care.	1	2	3	4	5	N/A
13. I would recommend this facility to family or friends.	1	2	3	4	5	N/A
14. I would return to this facility if I require physical therapy in future.	1	2	3	4	5	N/A

Comments: _____

