PATIENT INFORMATION

Date ____________________

Referred by: ____________________

Patient Name ____________________ Soc. Sec. # ____________________

Address ____________________

City ____________________ State __________ Zip Code ____________________

Age ______ Sex ________ Birthdate ________ Marital Status ____________________

Home Phone ____________________ Business or cell phone ____________________

Email address ____________________

Would you like to receive our free newsletter? ☐ YES ☐ NO

Employer ____________________

Employer's Address ____________________

Spouse or Parent's Name ____________________

INSURANCE COVERAGE

Name of Insurance Company ____________________

Ins. ID # ____________________ Group ____________________

Subscriber Name ____________________ Subscriber Date of Birth ____________________

Do you have secondary Insurance coverage? ☐ YES ☐ NO

Secondary Ins. Company ____________________

Secondary Ins. ID # ____________________ Group ____________________

Secondary Ins. Subscriber Name ____________________ Birth Date ____________________

Emergency Contact ____________________ Phone ____________________

342 Hamburg Turnpike, Suite 108
Wayne, NJ 07470

973-942-5904
FAX 973-904-1779

New Jersey Physical Therapy & Rehabilitation Associates, P.A.

GREGORY SCOTT, P.T.
JOHN D. HAYES, P.T.

(973) 942-5904
FAX: (973) 904-1779

FINANCIAL POLICY

IF YOUR INSURANCE IS AN HMO OR HMO MEDICARE:
Co-payment, as determined by your particular plan, will be due at the time of service. You are responsible for payment of any deductible, as determined by your insurance.

IF YOUR INSURANCE IS TRADITIONAL MEDICARE:
The copayment amount is determined by Medicare as per their own fee schedule, after bills are submitted to them. Copayments usually approximate $10.00 per session. **You** are responsible for payment of any deductible, and copay as determined by your insurance.

IF YOUR INSURANCE IS MAJOR MEDICAL:
Co-payment will be determined by your insurer after their processing of bills. No co-payment is payable at the time of service. You are responsible for payment of any deductible and copay, as determined by your insurance carrier.

IF YOUR INSURANCE IS WORKER'S COMPENSATION:
Neither co-payment nor deductible is applicable to this type of insurance.

IF YOUR INSURANCE IS MOTOR VEHICLE PLAN:
Co-payment and Deductible will be determined by your insurance carrier.

I have read the above statement. I will be responsible for copays and\or deductibles as determined by my insurer.

SIGNATURE____________________________ DATE_________

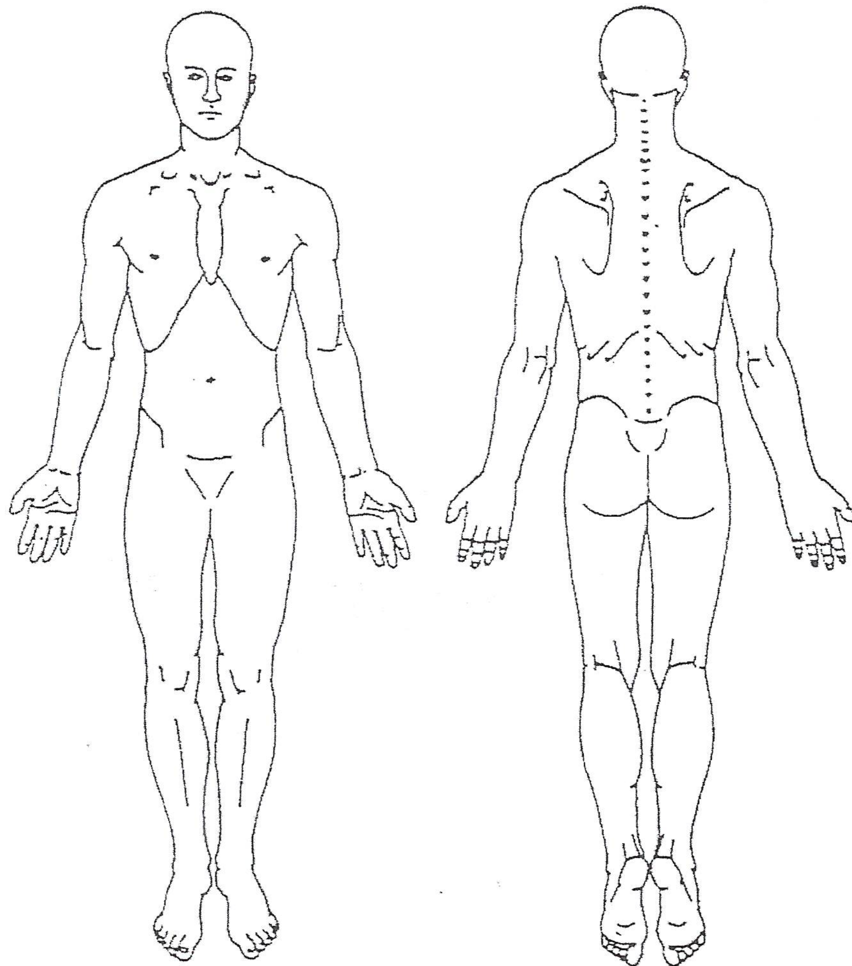
financia.viv

342 HAMBURG TURNPIKE, SUITE 108
WAYNE, NEW JERSEY 07470

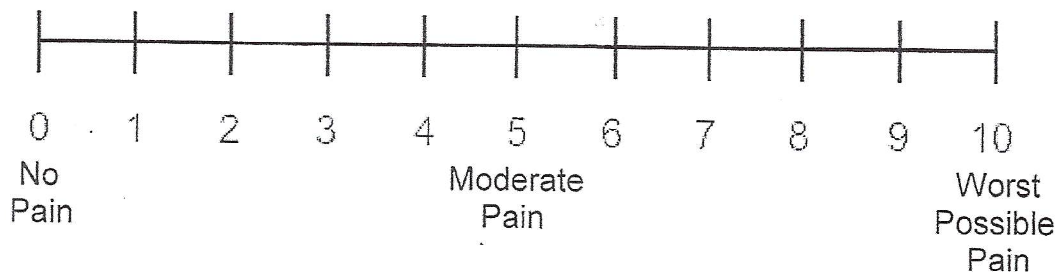
New Jersey Physical Therapy and Rehabilitation Associates, PA
342 Hamburg Turnpike, Suite 108
Wayne, NJ 07470 973-942-5904

Patient Name ______________________________ Date______________

Instructions: On the body diagram below, please indicate where your pain is located at the present time.



Indicate on the scale below how you would describe your present pain by placing a mark on the line.



342 Hamburg Turnpike, Suite 108 Wayne, NJ 07470 973-942-5904

PATIENT CONSENT FOR TREATMENT, RELEASE OF INFORMATION & INSURANCE PAYMENT ASSIGNMENT (Signature on File)

I, the undersigned, hereby authorize you to pay directly to New Jersey Physical Therapy And Rehabilitation Associates, PA, benefits due me under the terms of my policy issued by your company. Payment is authorized upon your receipt of their itemized statement for services rendered to me. This policy was in full force and effect at the time that these services were rendered.

Payment of this amount as herein directed, in whole or part shall be considered the same as if paid, by your company directly to me. I authorize use of this form on all my insurance submissions and authorize release of my medical records and information to my insurance companies or any agency handling my claims to secure processing and payment of benefits and to any of my medical doctors or medical facilities relating to my treatment and release of my medical records to a subpoena which asks specifically for them. I understand that I am responsible for my bill. I authorize New Jersey Physical Therapy and Rehabilitation Associates, PA to act as my agent in helping to obtain payment from my insurance companies. I permit a copy of this authorization to be used in place of the original.

I hereby consent to such evaluation and treatment procedures and patient care, which, in the judgment of my therapist is considered necessary or advisable while a patient at New Jersey Physical Therapy And Rehabilitation Associates.

Signature (Parent/Guardian, if minor) ______________________________

Printed Name ______________________________ Date ____________________

Name ____________________________________

Age ________________ Gender M___ F____

Occupation ____________________________________

Are there stairs in home? Yes ________ No _________

Do you use a cane, walker or wheelchair? ___________

Do you wear glasses or a hearing aid? ______________

Have you fallen in past year? _____YES _____ NO

If yes, how many falls? _________________

Did you get injured in a fall? ____ YES _______NO

Do you have a pacemaker? ________________________

MEDICAL HISTORY-Please circle if you have ever had:

Arthritis	Broken bones/fractures
Osteoporosis	Blood disorders/clots
High Cholesterol	Circulation/vascular problems
Heart Problems	High blood pressure
Gastric reflux	Seasonal allergies
Lung Problems	Stroke
Diabetes	Head injury
Multiple Sclerosis	Parkinson's disease
Seizures/epilepsy	Thyroid problems
Cancer	Developmental or growth problems
Tuberculosis	Hepatitis
Kidney Problems	Skin Diseases
Depression	Repeated infections

Other major illnesses:

____

____

SURGERIES:

____

____

____

____

Have you **recently** noted: (please circle which apply)

Weight Loss/Gain	Fatigue
Fever/Chills/Sweats	Dizziness
Nausea/vomiting	Pain at night
Weakness	Shortness of breath
Difficulty Swallowing	Headaches
Numbness/Tingling	Change of appetite
Bowel/urinary problems	

List any accidents or injuries you have had and include dates:

____

____

____

____

____

____

____

MEDICATIONS- Indicate by circling which types of over the counter medications you take:

Advil/Aleve	Tylenol
Allergy control	Aspirin
Decongestants	Antacids
Ibuprofen	Herbal Supplements

Other: ____________________________________

____

____

List any prescription medications that you take:

____

____

____

____

____

____

____

____

____

____

Describe the symptoms and complaints/condition that you are seeking treatment for today and how long you have had the condition (date of onset):____

____

____

____

Have you had any previous episodes of this condition, and if so, when? ____________________________

____

Please place a checkmark by any diagnostic testing you have had: X-rays____ MRI ____ CT scan ____ Blood test ____
Nerve Conduction Velocity/EMG ____ Cardiac Stress Test ____ Doppler/circulation Studies ____
Other: ____

____

Was the onset of this condition due to: Accident/Injury_____ Slow/gradual onset _____ Work Related _____
Sports/recreation _____ Repetitive activity ______ Unknown ______ Other: ______________________

What is the frequency of your pain/symptoms? Constant ____ Frequent ____ Intermittent _____
What is your pain intensity level on a scale of 0 – 10 (0=no pain, 10= worst imaginable pain)? ________

How would you describe your pain/symptoms? Improving ____ Staying the same ____ Worsening _____
Can you describe any specific remedies, movements or activities that **decrease** your pain/symptoms? __________

____

Does your pain/symptoms radiate to your arms or legs and if so, where? ___________________________

____

Which of the following describes the type of pain you have? Sharp ____ Dull ____ Aching ____ Burning _____
Stabbing ____ Throbbing _____ Other: ____________________________________
Do you have a feeling of numbness, tingling or weakness anywhere in your body? If so, where? ______________

____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ____________________ **Date** __________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score ______

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** ____________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

Sleeping

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

Walking

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

Traveling

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score ______

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{sum of n responses}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may not be calculated if there is greater than 1 missing item.