ARS Hand and Physical Therapy

505 Morris Avenue, Suite 103

Springfield, NJ 07081

PLEASE COMPLETE ALL INFORMATION

HOW DID YOU HEAR ABOUT US? ☐ PHYSICIAN ☐ FRIEND ☐ AD ☐ ONLINE ☐ OTHER ________________________________

PHYSICIAN/FRIEND (NAME): ____

EMAIL ADDRESS: ____

LAST NAME ________________________________ MIDDLE ____________ FIRST ______________________

STREET ADDRESS ____

CITY____ STATE____________ ZIP____________________

HOME PHONE ____________________ WORK PHONE ______________ CELL PHONE __________________

SOCIAL SECURITY # _______-_______-_______ DATE OF BIRTH ________________AGE ______SEX ________

MARITAL STATUS: MARRIED__________ SINGLE ___________ DIVORCED__________WIDOWED__________

SPOUSE'S NAME ____

EMPLOYER ____

OCCUPATION ________________________________ FULL TIME ______ PART-TIME______RETIRED______

INSURANCE INFORMATION

WORKERS COMPENSATION INFORMATION

EMPLOYER'S NAME ____

ADDRESS ____

CITY____ STATE____________ ZIP____________________

TELEPHONE # OF EMPLOYER ____________________ SUPERVISOR'S NAME __________________________

DATE OF INJURY ______ /______ /______ LAST DAY WORKED _______/_______/_______

ARE YOU CURRENTLY WORKING? YES _____ NO _____ LIGHT DUTY _____ AS OF ______/______/______

WORKER'S COMPENSATION INSURANCE COMPANY NAME ______________________________________

ADDRESS ____

CITY____ STATE________________ ZIP________________

TELEPHONE # OF INSURANCE COMPANY ____________________ ADJUSTER'S NAME ____________________

CLAIM # ________________________

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS ALL CLAIMS.

SIGN ____DATE ____________________

I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO ADVANCED REHAB SOLUTIONS FOR SERVICES RENDERED.

SIGN ____DATE ____________________

I HAVE RECEIVED MY NOTICE OF PRIVACY POLICIES FROM ADVANDED REHAB SOLUTIONS

SIGN ____DATE ____________________

PATIENT CONFIDENTIALITY

In this office, **Patient Confidentiality** is a prime concern. Please indicate below with whom our office can or cannot leave a message. Please check where appropriate.

	YES	NO	DOES NOT APPLY
Spouse	___	___	___
Parent	___	___	___
Children	___	___	___
Answering Machine	___	___	___
Home	___	___	___
Work	___	___	___

Are we you able to receive telephone calls at your work place? Yes ______ No ______

May we call you at your work place and state who is calling? Yes ______ No _______

Due to confidentiality regulations, should a family member, friend or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.

Please check with whom we may discuss your situation.

	YES	NO	DOES NOT APPLY
Spouse	___	___	___
Children	___	___	___
Parent	___	___	___

Parent, Children, Spouse and/or Significant Others:

Name____
Relationship ____
Phone ____

Name ____
Relationship ____
Phone ____

Patient Name _________________________________ Age_________ Today's Date_______________________
Occupation:_____________________________ Are you on a work restriction from your doctor? Yes No
If yes, what restrictions____
Activities that comprise your workday (I.E. Computer/Lifting)____
Leisure activities/exercise routines:____
Do you smoke? Yes No If yes how much? _____________Packs/Day
Drink alcohol? YES NO If yes how much? ______________Drinks/week
FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO
ALLERGIES: ____

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue	❑ numbness or tingling	❑ constipation
❑ fever/chills/sweats	❑ muscle weakness	❑ diarrhea
❑ nausea/vomiting	❑ dizziness/lightheadedness	❑ shortness of breath
❑ weight loss/gain	❑ heartburn/indigestion	❑ fainting
❑ difficulty maintaining balance while walking	❑ difficulty swallowing	❑ cough
❑ falls	❑ changes in bowel or bladder function	❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ depression	❑ thyroid problems
❑ heart problems	❑ lung problems/asthma	❑ diabetes
❑ chest pain/angina	❑ tuberculosis	❑ osteoporosis
❑ high blood pressure	❑ osteoarthritis	❑ multiple sclerosis
❑ circulation problems	❑ rheumatoid arthritis	❑ epilepsy
❑ blood clots	❑ other arthritic condition	❑ eye problem/infection
❑ stroke	❑ bone or joint infection	❑ ulcers
❑ anemia	❑ kidney problem/infection	❑ liver problems
❑ AIDS/HIV	❑ bladder/urinary tract infection	❑ hepatitis
❑ chemical dependency (i.e., drugs/alcoholism)	❑ pelvic inflammatory disease	❑ pneumonia

List any other medical problems____

Do you have any significant immediate family history of illness or disease? YES NO If yes please list

____
____
____

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Please list any medications you are currently taking or provide us a list and we will attach to your chart:

1. ______________________ 2.__________________________ 3.______________________________

4. ______________________ 5. __________________________ 6.______________________________

Have you ever taken steroid medications for any medical conditions? **YES NO If yes how long_________**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries including dates:

1. ______________________ 2.__________________________ 3.______________________________

4.______________________ 5.__________________________ 6.______________________________

What are your current symptoms?____

What do you think caused your symptoms? ____

Approximately when did they start?____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

Treatment received so far for this problem (chiropractic, injections, etc) ____________________________

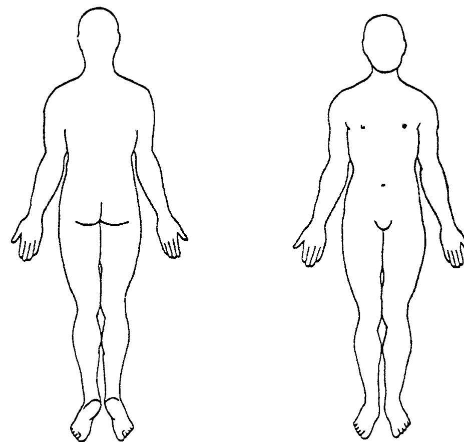
Please list special tests performed for this problem (x-ray, MRI, labs, etc) ____________________________

Have you ever had this problem before: YES NO If yes, when __________________________________

Treatment received ____**Was there improvement? YES NO**

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:



X Shooting/sharp pain
O Dull/aching pain
/ Numbness or Tingling

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please circle:

Your current level of pain while completing this survey: 0 1 2 3 4 5 6 7 8 9 10 out of 10

The best your pain has been during the past 48 hours: 0 1 2 3 4 5 6 7 8 9 10 out of 10

The worst your pain has been during the past 48 hours: 0 1 2 3 4 5 6 7 8 9 10 out of 10

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. ____
2. ____
3. ____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. ____
2. ____
3. ____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

Signature of Patient___________________________ **Reviewed by Therapist**__________________________ **Date** _____________