ARJC

550 Newark Ave, Ste 304
Jersey City, NJ 07306
Ph: 201-624-2111 Fax: 201-795-0148

Name: _____ SS#_____

Address: _____City:_____ State: _____Zip: _____

Birth Date: _____Sex: _____ Age:_____ Marital Status: _____

# of Children:_____ Occupation: _____ FT, PT, Light Duty, Disabled

Employer:_____ E-mail_____

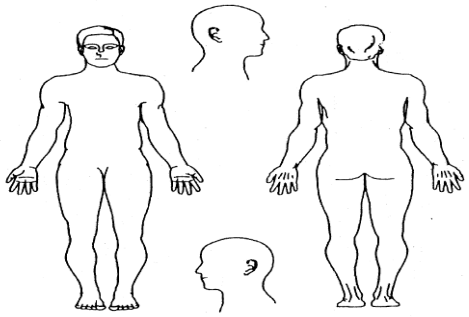
Home Phone: _____Work Phone #:_____Cell Phone: _____

MD's name _____ Phone # _____Fax#_____

Reason for visit today?_____

_____

Presenting Pain Pattern	
Place an "X" on the drawing below on areas causing pain and a letter describing it	A=Ache B=Burning S=Stabbing N=Numbness P= Pines & Needles C-Coldness W=Weakness



Do you have:

Asthma ☐ Bladder ☐ Bloating/ Gas ☐ Blurry vision ☐
Bothered by light ☐ Bunions/ Corns/ callus ☐ Burning: Hands ☐ Feet ☐ Chest Pain ☐
Constipation ☐ Cold: Hands☐ Feet ☐ Diarrhea ☐ Dizziness ☐
Excessive Thirst ☐ Excessive Hunger ☐ Excessive Urination ☐ Flat feet/ ankle pain ☐
Headaches ☐ Heartburn ☐ Loss of balance ☐ Kidney ☐
Menstrual Problems ☐ Nausea ☐ Nervousness ☐ Night Sweats ☐
Numbing: Hands ☐ Feet ☐ Pins and needles sensation: Hands☐ Feet ☐ Prostate Condition ☐
Recent loss of weight ☐ Rib Pain ☐ Ringing in the Ears☐ Sinus ☐
Shortness of breathe ☐ Vascular Problems ☐ Warts/ ingrown toenail ☐

Past Surgeries/ Trauma's/ Broken Bones:_____

_____

_____

Medications you're taking for each Condition? (example: Lipitor for cholesterol, etc…)_____

_____

Current or Past Injuries/ Accidents:_____

_____

_____

Family history of Diabetes, High blood Pressure, Cancer, etc**?**_____

_____

Current or past illnesses: Diabetes/ Cancer/ Tuberculosis:_____

_____

Current or prior use of Cigarettes or Alcohol? If yes, for how many years and consumption amount per day?

_____

_____

Current or prior treatment: Chiropractic, Physical Therapy, Injections? Good or poor benefit:

_____

_____

_____

Recent Tests? MRI, X-ray, Nerve conductions, CT scan, sleep study:_____

_____

_____

_____

_____

We accept some insurance coverage and by signing below you authorize Advanced Rehabilitation of Jersey City to bill your insurance for you. Any services not covered by your insurance company will be your responsibility.
Insurance:_____ID#:_____Policy holders name _____
D.O.B. ___/____/___
Signature:_____Date:_____

Parental Consent (if under 18 years of age)_____

Patient Name:_____ Sign_____
Doctors Name:_____ Sign_____ Date:_____

Neck Pain? Yes No Left Right **Problem** started a week, month, year?_____

Result of? unknown, work, auto accident? _____
Pain scale (1-mild 5- moderate 10-extreme) circle one **1 2 3 4 5 6 7 8 9 10** Percent with pain? **25 50 75 100**
Quality (Circle all that apply) Sharp, Dull, Ache, Burning, Stabbing, Numbing, Tingling, Weakness?

_____

Radiates to (Circle all that apply) Left or right shoulder, Left or right elbow, Left or right hand,

_____

Aggravated by? (Circle all that apply) turning, twisting, bending, sleeping, lifting, reading?_____
Relieved by? (Circle all that apply) ice, heat, medication, sitting, lying,? _____
Timing? (Circle all that apply) Wake up with pain, at end of day, during sleep? _____

Low Back Pain? Yes No Left Right **Problem** started a week, month, year?_____

Result of? unknown, work, auto accident? _____
Pain scale (1-mild 5- moderate 10-extreme) circle one **1 2 3 4 5 6 7 8 9 10** Percent with pain? **25 50 75 100**
Quality (Circle all that apply) Sharp, Dull, Ache, Burning, Stabbing, Numbing, Tingling, Weakness,?

_____

Radiates to (Circle all that apply) Left or right buttock, Left or right leg, Left or right knee, Left or right foot,

_____

Aggravated by? (Circle all that apply) walking, sitting, standing, lying, bending, lifting, ?_____
Relieved by? (Circle all that apply) ice, heat, medication, walking, sitting, standing, lying,? _____
Timing? (Circle all that apply) Wake up with pain, at end of day, during sleep? _____

Headaches Yes No Left Right (1-10___ % _____) **pain is sharp, dull, ache, stabbing, _____**
Located in front, left, right side, back of head
Aggravated by? (Circle all that apply) reading, concentrating ?_____

Dizziness Yes No **Loss of balance** Yes No _____

Shoulder Pain Yes No Left Right (1-10___ % _____) **pain is sharp, dull, ache, stabbing, shooting**
Aggravated by? (Circle all that apply) carrying, holding objects, raising arm, lifting,?_____
Elbow Pain Yes No Left Right (1-10___ % _____) **pain is sharp, dull, ache, stabbing, shooting**
Wrist Pain Yes No Left Right (1-10___ % _____) **pain is sharp, dull, ache, stabbing, shooting**
Jaw Pain Yes No Left Right (1-10___ % _____) **pain is sharp, dull, ache, stabbing, shooting**
Hip Pain Yes No Left Right (1-10___ % _____) **pain is sharp, dull, ache, stabbing, shooting**
Aggravated by? (Circle all that apply) walking, sitting,, climbing stairs,?_____
Knee Pain Yes No Left Right (1-10___ % _____) **pain is sharp, dull, ache, stabbing, shooting**
Aggravated by? (Circle all that apply) walking, sitting,, climbing stairs, bending knee ?_____
Foot Pain Yes No Left Right (1-10___ % _____) **pain is sharp, dull, ache, stabbing, shooting**
Aggravated by? (Circle all that apply) walking, sitting,, climbing stairs, flexing ?_____

Patient Name:_____ Sign_____
Doctors Name:_____ Sign_____ Date:_____