North Jersey Professional Rehabilitation, LLC
122 North Church Road, Lower Level
Sparta, NJ 07871

Phone: 973-940-8910 Fax: 973-940-8918

Patient Information

Patient Name: _____ Birthdate: / /
Last First M.I.
Social Security #: _____ Gender: M / F Marital Status: M S D W
Street Address: _____
City: _____ State: _____ Zip Code: _____
Occupation: _____ Employer's Name: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Subscriber

Relationship to Patient: Self _____ Spouse _____ Other _____
Patient Name: _____ Birthdate: _____
Last First M.I.
Social Security #: _____ Gender: _____ Marital Status: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Occupation: _____ Employer's Name: _____
Emp. Address: _____
Emp. City: _____ Emp. State: _____ Emp. Zip Code: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Accident Information

Accident/Injury Onset Date: Surgery: Yes / No Date: _____
Accident Type: None W/C Auto Other Accident details: _____

Insurance Information

Primary Insurance Company: _____ Contact: _____
Phone: ( ) _____ Policy/Claim #: _____ Group: _____
Insured's Name: _____ Authorization # / Precert #: _____

Secondary Insurance Co. _____ Contact: _____
Phone: ( ) _____ Policy Claim #: _____ Group: _____
Insured's Name: _____ Social Security #: _____ Birthdate: _____

Referral Information

Referring MD: _____ Phone: _____ NPI #: _____
Admit Date: _____ Rx Date: _____ Therapist's Name: _____
Body part/duration: _____
Have you received OT, chiropractic or physical therapy in the past year? _____

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Patient Medical History

Name: _____

Referring Physician: _____

Have you had surgery for this injury? YES / NO (Circle one) Date of injury: _____ Date of surgery: _____

Are you currently taking any prescription medication or non-prescription medication? YES / NO (Circle one)

List ALL medications separated by commas: _____

Please select from the list below if you have had an evaluation for this injury by any of the following practitioners.

☐ General Physician
☐ Orthopedist
☐ Emergency Room Physician
☐ Neurologist
☐ Physical Therapist
☐ Occupational Therapist
☐ Podiatrist
☐ Chiropractor
☐ Other: _____

Please select if you have had any of the following special tests – check off all that apply:

☐ X-Ray
☐ MRI
☐ CT Scan
☐ Bone Scan
☐ EMG / NVC
☐ Myelogram

Please select to indicate current or past medical history – check off all that apply:

☐ Arthritis/Swollen Joints
☐ Anemia
☐ Asthma/Bronchitis/Emphysema
☐ Coronary Heart Disease
☐ Pacemaker/Defibrillator
☐ Diabetes
☐ Emotional/Psychological Conditions
☐ Epilepsy/Seizures
☐ Gout
☐ High Blood Pressure
☐ Hernia
☐ Infectious Disease
☐ Joint Replacement
☐ Pins/Metal Implants
☐ Osteoporosis
☐ Pregnant
☐ Stroke/TIA
☐ Thyroid Condition

Orthopedic Conditions
☐ Back: Injury/Surgery
☐ Neck: Injury/Surgery
☐ Shoulder: Injury/Surgery
☐ Elbow/Wrist/Hand: Injury/Surgery
☐ Knee: Injury/Surgery
☐ Foot/Ankle: Injury/Surgery