Outpatient Rehabilitation Department
Medical History Form

Name: _____ Birth Date: _____
Referring Doctor: _____ Primary Care Physician: _____
Phone Number: Home _____ Email: _____
Cell _____

Reason you are attending therapy: _____

Please check any of the following whose care you have been under (past year):
_____Medical Doctor (MD) _____ Psychiatrist/Psychologist
_____Orthopedic Doctor _____ Physical Therapy
_____Dentist _____ Chiropractor
_____Other (Explain) _____

Why have you seen the above? In addition, include any emergency room trips and prior hospitalizations. Fill in dates and Explanation below.
_____
_____
_____

If you have a history of any of the following, please indicate below:

☐ Cancer: What type?	☐ Lymes Disease
☐ Heart Problems	☐ Rheumatoid Arthritis
☐ Pacemaker	☐ Osteoarthritis
☐ High Blood Pressure	☐ Fibromyalgia Syndrome(FMS)
☐ Diabetes	☐ Depression
☐ DVT/blood clots	☐ Thyroid Problems
☐ Circulation problem	☐ Joint Replacement
☐ Osteoporosis	☐ Multiple Sclerosis
☐ Asthma	☐ Seizures
☐ Emphysema/Bronchitis	☐ Epilepsy
☐ Tuberculosis	☐ Stroke
☐ Kidney Disease	☐ Alcoholism, Illicit Drug Use
☐ HIV Disease/AIDS	☐ Hepatitis
☐ Latex Allergy	☐ Gout
☐ Other Allergies: Explain	☐ Other: Explain

During the past month, have you been feeling down, depressed or hopeless? YES NO
During the past month, have you had little interest in doing things? YES NO
Do you feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO
Date of last menstrual period: _____

Please Describe any significant injuries for which you have been treated (including fractures, sprains, etc. and the approximate date off injury.

Date	Injury	Date	Injury

Which of the following OVER-THE-COUNTER medication have you taken in the past week?

Yes	No	Aspirin
Yes	No	Tylenol
Yes	No	Advil/Motrin/Ibuprofen
Yes	No	Laxatives
Yes	No	Decongestant
Yes	No	Antihistamines
Yes	No	Antacid
Yes	No	Vitamins/Mineral supplement
Yes	No	Other

Please list any PRESCRIPTION medication you are currently taking (INCLUDING tablets, capsules, patches, and/or injections).

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

How many caffeinated coffee or caffeine containing beverages do you drink per day? _____
Do you smoke? Yes ____ No ____
If you do smoke, how many cigarettes do you smoke a day? _____
How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? ___

Have you recently noted:

Yes	No	Unexplained weight loss or weight gain
Yes	No	Nausea/Vomiting
Yes	No	Fatigue
Yes	No	Weakness
Yes	No	Fever/chills/sweats
Yes	No	Numbness/tingling
Yes	No	Dizziness when you stand up
Yes	No	Chest pain
Yes	No	Shortness of breath

Patient signature_____ Date_____

Therapist Signature _____ Date_____

Hackensack UMC Mountainside

1 Bay Avenue
Montclair, NJ 07042

Welcome to the Rehabilitation Department at Hackensack UMC Mountainside. Our highly qualified and motivated staff is here to make your rehabilitation experience beneficial as well as enjoyable. To ensure this, we are providing some simple guidelines to follow:

- Please double check with your insurance company to make sure that we do participate with your plan. Ultimately, you are responsible for any financial obligations that are associated with your insurance.
- If your insurance requires a pre-certification there may be delay in your follow up visit. The rehabilitation department will notify you when the authorization is received.
- If you have a Co-payment, it is required prior to services being rendered.
- If you accumulate three no shows or cancelled appointments you will may discharged for the services you are receiving at the Outpatient Department of Hackensack UMC Mountainside. You will not be permitted to schedule future appointment at this facility without written consent from the Director of Rehabilitation Services.
- Please be prompt with your scheduled appointment so we can maximize your treatment. If you are arriving late, your treatment time is subject to cancellation and rescheduling.
- Please bring or wear proper clothing to make you affected treatment area accessible. We do provide changing rooms with lockers for you convenience.(Please bring your own lock)
- In case of inclement weather, please call ahead of time to confirm your appointment.
- Use of cellular phones is prohibited inside the gym area. Please turn off your cellular phone when you are inside of the gym.
- Anyone who is under the age of 18 in the reception/waiting area unattended. Please make arrangement for your children before coming to Physical Therapy.
- Most importantly, please communicate with your therapist! The more information that is known the better we can help you recover.

By following these simple guidelines, together we can reach your goal in the shortest amount of time.
Thank you again for choosing us as your rehabilitation provider.

Please sign to acknowledge that you have read and understood the guidelines.

_____ _____
Patient Signature Date

_____ _____
Signature of legal Guardian-Health Care Agent, or other personal Representative Date

_____ _____
Witness Signature Date

Hackensack UMC Mountainside
1 Bay Avenue
Montclair, NJ 07042

Insurance Authorization/Pre-certification information

Welcome to the Rehabilitation Department at Hackensack UMC Mountainside. Our staff will make every effort to work with you and your insurance company. However, the following conditions apply:

- Please be advised that some insurance companies require pre-certification/ authorization before starting any physical therapy treatment
- Please follow up with your insurance company to confirm whether you are required to obtain a pre-certification/ authorization
- Please inform your insurance company that all authorizations must be faxed to the Hackensack UMC Mountainside Rehabilitation Department at the following fax number 973-680-7917
- The authorization should include the amount of visits approved by your insurance company and the date span for the visits along with an authorization number
- Pre-certification/ authorization may delay your follow up appointment. To avoid a longer waiting period please contact your insurance company to expedite approval
- After your initial evaluation a member of our staff will fax the appropriate documentation to your insurance company for approval
- You are ultimately responsible for the follow up and ensure that authorization has been granted before starting treatments
- Failure to obtain an authorization from your insurance company will result in you being personally responsible for any financial obligations that are associated with your treatments

By following these guidelines and working together we hope to ensure a positive experience at Hackensack UMC Mountainside. Thank you again for choosing us as your rehabilitation provider!

_____ _____
Patient Signature Date

_____ _____
Signature of legal Guardian-Health Care Agent, or other personal Representative Date

_____ _____
Witness Signature Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1 – What is your pain RIGHT NOW?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Examiner's Signature

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity **A I have no pain at the moment.** **B The pain is very mild at the moment.** **C The pain is moderate at the moment.** **D The pain is fairly severe at the moment.** **E The pain is very severe at the moment.** **F The pain is the worst imaginable at the moment.**	***SECTION 6 - Concentration*** **A I can concentrate fully when I want to with no difficulty.** **B I can concentrate fully when I want to with slight difficulty.** **C I have a fair degree of difficulty in concentrating when I want to.** **D I have a lot of difficulty in concentrating when I want to.** **E I have a great deal of difficulty in concentrating when I want to.** **F I cannot concentrate at all.**
SECTION 2 -Personal Care (Washing, Dressing, etc.) **A I can look after myself normally without causing extra pain.** **B I can look after myself normally, but it causes extra pain.** **C It is painful to look after myself and I am slow and careful.** **D I need some help, but manage most of my personal care.** **E I need help every day in most aspects of self care.** **F I do not get dressed, I wash with difficulty and stay in bed.**	***SECTION 7 - Work*** **A I can do as much work as I want to.** **B I can only do my usual work, but no more.** **C I can do most of my usual work, but no more.** **D I cannot do my usual work.** **E I can hardly do any work at all.** **F I cannot do any work at all.**
SECTION 3 - Lifting **A I can lift heavy weights without extra pain.** **B I can lift heavy weights, but it gives extra pain.** **C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.** **D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** **E I can lift very light weights.** **F I cannot lift or carry anything at all.**	***SECTION 8 - Driving*** **A I can drive my car without any neck pain.** **B I can drive my car as long as I want with slight pain in my neck.** **C I can drive my car as long as I want with moderate pain in my neck.** **D I cannot drive my car as long as I want because of moderate pain in my neck.** **E I can hardly drive at all because of severe pain in my neck.** **F I cannot drive my car at all.**
SECTION 4 - Reading **A I can read as much as I want to with no pain in my neck.** **B I can read as much as I want to with slight pain in my neck.** **C I can read as much as I want to with moderate pain in my neck.** **D I cannot read as much as I want because of moderate pain in my neck.** **E I cannot read as much as I want because of severe pain in my neck.** **F I cannot read at all.**	***SECTION 9 - Sleeping*** **A I have no trouble sleeping.** **B My sleep is slightly disturbed (less than 1 hour sleepless).** **C My sleep is mildly disturbed (1-2 hours sleepless).** **D My sleep is moderately disturbed (2-3 hours sleepless).** **E My sleep is greatly disturbed (3-5 hours sleepless).** **F My sleep is completely disturbed (5-7 hours)**
SECTION 5 - Headaches **A I have no headaches at all.** **B I have slight headaches which come infrequently.** **C I have moderate headaches which come infrequently.** **D I have moderate headaches which come frequently.** **E I have severe headaches which come frequently.** **F I have headaches almost all the time.**	***SECTION 10 - Recreation*** **A I am able to engage in all of my recreational activities with no neck pain at all.** **B I am able to engage in all of my recreational activities with some pain in my neck.** **C I am able to engage in most, but not all of my recreational activities because of pain in my neck.** **D I am able to engage in a few of my recreational activities because of pain in my neck.** **E I can hardly do any recreational activities because of pain in my neck.** **F I cannot do any recreational activities at all.**

COMMENTS:_____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

NECK PAIN DISABILITY QUESTIONAIRE

PATIENT NAME: _____ **DATE:** _____

Este questionaire se diseña para permitirnos entender cuánto ha afectado su dolor de cuello su capacidad de manejar sus actividades diarias. Respuesta de Pelase cada sección circundando la UNA declaración que la mayoría aplicaron a usted. Realizamos que usted puede sentirse que más de una declaración puede relacionarse con usted, pero POR FAVOR, círculo justo la una opción que ahora describe de cerca sus problemas.

Sección 1 - La intensidad
1. del dolor no tengo ningún dolor en el momento.
2. El dolor es muy suave en el momento.
3. El dolor es moderado en el momento.
4. El dolor es bastante severo en el momento.
5. El dolor es muy severo en el momento.
6. El dolor es el imaginable peor en el momento.

Sección 2 - El cuidado personal
1. puedo ocuparme normalmente sin causar dolor adicional.
2. Puedo ocuparme normalmente, pero causa dolor adicional.
3. Es doloroso ocuparse y tengo lento y cuidado.
4. Necesito una cierta ayuda, pero manejo la mayoría de mi cuidado personal.
5. Necesito ayuda cada día en la mayoría de los aspectos del uno mismo-cuidado.
6. No consigo vestido. Me lavo con dificultad y permanezco en cama.

Sección 3 - Levantando
1. puedo levantar pesos pesados sin dolor adicional.
2. Puedo levantar pesos pesados, pero causa dolor adicional.
3. El dolor evita levante pesos pesados del piso, pero puedo manejar si se colocan convenientemente, e.g. en un dolor de la tabla
4. evita que levante pesos pesados, pero puedo manejar la luz a los pesos medios si se colocan convenientemente.
5. Puedo levantar pesos muy ligeros.
6. No puedo levantar o llevar cualquier cosa en todos.

Sección 4 – Leyendo
1. puedo leer tanto como deseo sin al dolor en mi cuello.
2. Puedo leer tanto como deseo con al dolor leve en mi cuello.
3. Puedo leer tanto como deseo con al dolor moderado en mi dolor en mi cuello. 4. No puedo leer tanto como deseo debido a dolor moderado en mi cuello.
5. No puedo leer tanto como deseo debido a dolor severo en mi cuello.
6. No puedo leer en todos.

Sección 5 - Los dolores de cabeza
1. no tengo ningún dolor de cabeza en todos.
2. Tengo dolores de cabeza leves, que vienen infrecuentemente.
3. Tengo dolores de cabeza moderados, que vienen infrecuentemente.
4. Tengo dolores de cabeza moderados, que vienen con frecuencia.
5. Tengo dolores de cabeza severos, que vienen con frecuencia.
6. Tengo dolores de cabeza casi todos del tiempo.

Sección 6 - Concentración
1. que puedo concentrarme completamente cuando deseo sin a la dificultad.
2. Puedo concentrarme completamente cuando deseo con a la dificultad leve.
3. Tengo un grado justo de la dificultad en concentrarse cuando deseo a.
4. Tengo muchos de la dificultad en concentrarse cuando deseo a.
5. Tengo dificultad mucha en concentrarse cuando deseo a.
6. No puedo concentrarme en todos.

Sección 7 - El trabajo
1. puedo hacer tanto trabajo como deseo a.
2. Puedo hacer solamente mi trabajo generalmente, pero no más.
3. Puedo hacer la mayoría de mi trabajo generalmente, pero no más.
4. No puedo hacer mi trabajo generalmente.
5. Puedo hacer apenas cualquier trabajo en todos.
6. No puedo hacer ningún trabajo en todos.

Sección 8 – Conduciendo
1. puedo conducir mi coche sin ningún dolor de cuello.
2. Puedo conducir mi coche mientras deseo con dolor leve en mi cuello.
3. Puedo conducir mi coche mientras deseo con dolor moderado en mi cuello.
4. No puedo conducir mi coche mientras deseo debido a dolor moderado en mi cuello.
5. Puedo conducir apenas en todos debido a dolor severo en mi cuello.
6. No puedo conducir mi coche en todos.

Sección 9 - El dormir
1. no tengo ningún dormir del apuro.
2. Mi sueño se disturba levemente (menos de 1 hora de sleepless).
3. Mi sueño se disturba suavemente (1-2 horas de sleepless).
4. Mi sueño se disturba moderado (2-3 horas de sleepless).
5. Mi sueño se disturba grandemente (3-5 horas de sleepless).
6. Mi sueño se disturba totalmente (5-7 horas de sleepless).

Sección 10 - La reconstrucción
1. puedo enganchar a todas mis actividades recreacionales, sin dolor de cuello en todos.
2. Puedo enganchar a todas mis actividades recreacionales, con un cierto dolor en mi cuello.
3. Puedo contratar adentro la mayoría, pero no todas mis actividades recreacionales generalmente debido a dolor a mi cuello.
4. Puedo enganchar a algunas de mis actividades recreacionales generalmente debido a dolor en mi cuello.
5. Puedo hacer apenas cualquier actividad recreacional debido a dolor en mi cuello.
6. No puedo hacer ninguna actividades recreacional en todo