



Physical Medicine and Rehabilitation
for New York and Connecticut

CONFIDENTIAL PATIENT CASE HISTORY

Name: _____ Social Security# _____

Address: _____ City _____ State _____ Zip _____

Home Phone #: _____ Work Phone #: _____

Age: _____ Birth Date: _____ # of Children: _____

Marital Status: M S W D (please circle) Occupation: _____

Spouse's Name: _____ Spouse's Work Phone #: _____

Nearest Relative & Phone #: _____

Referred By: _____

HEALTH INFORMATION

What is your major complaint? _____

Other Complaints: _____

How long have you had this condition? _____

Have you had this or similar condition in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Y - N -CONSTANT -COMES AND GOES

Does this interfere with your: WORK -SLEEP-DAILY ROUTINE- OTHER (please circle)

Other doctors who treated this condition: _____

List surgical operations and year performed: _____

Drugs you take now: ___ Nerve Pills ___ Pain Killers ___ Muscle Relaxers

___ Pep Pills ___ Tranquilizers ___ Insulin

___ Birth Control ___ Others: _____

Age of mattress _____ Comfortable ___ Uncomfortable

Are you wearing: ___ Heel lifts ___ Sole Lifts ___ Inner soles ___ Arch supports

Have you been in an auto accident? ___ Past yr ___ Past 5 yrs ___ Over 5 yrs ___ Never

Describe: _____

Have you had any other personal injury or accident?

___ Past yr ___ Past 5 yrs ___ Over 5 yrs ___ None

Describe: _____

Contact Us:

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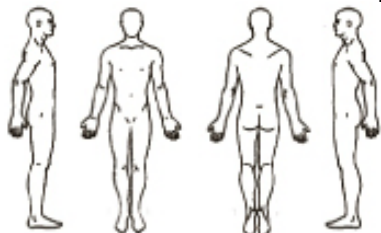
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Date of Last Physical Exam: _____

Please mark your area of pain
On the figure below:



- Have you ever suffered from:
- Dizziness Backache
 - Heart Trouble Diabetes
 - Arthritis Headaches
 - Asthma Neuritis
 - Digestive Disorders
 - Nervousness Sinus Trouble
 - Neck Pain

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? Y N

Do you have Health Insurance? Y N

Name of Company _____ Policy # _____

Are you covered by Medicare? Y N

Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports or forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office, will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by: Cash Check Credit Card
 Mastercard Visa Amex

Card # _____ Exp. Date: _____

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ SS # _____

Doctors Signature: _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health)

<u>Name</u>	<u>Relation</u>	<u>Past and Present Health Problems</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____