PARAMUS
MEDICAL & SPORTS REHABILITATION CENTER
The innovative therapy team that gets results

New Patient Registration/ Health History

Name _____ Date _____

Sex _____ Home Phone _____ Cell Phone _____

Address _____
City State Zip

Date of Birth _____ (mm/dd/yyyy)

Email Address _____

Occupation _____

Place of Birth _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Height _____ Weight _____ Last Four of SS# _____

Referred by _____

Chief Complaint _____

Medical History of Chief Complaint

_____

_____

Date of Onset _____ (mm/dd/yyyy)

Have you experienced this before?
☐ No ☐ Yes

List any previous treatments for this condition including any hospitalizations, surgeries, medications, physical therapy, exams, lab tests (blood analysis, X – Ray, MRI, ect.)

_____

_____

_____

_____

Does this condition interfere with your daily activities (work, exercise, sleep, sex,ect.)?

_____

Medical doctor's name , address & Phone Number

_____

Date of the last visit and diagnosis _____

Family History:

Illness:

☐ Father ☐ Mother

☐ Sibling ☐ Spouse

☐ Children

Cancer:

☐ Father ☐ Mother

☐ Sibling ☐ Spouse

☐ Children

Diabetes:

☐ Father ☐ Mother

☐ Sibling ☐ Spouse

☐ Children

High blood pressure/ Heart Disease:

☐ Father ☐ Mother

☐ Sibling ☐ Spouse

☐ Children

Allergies (food, dust, etc):

☐ Father ☐ Mother

☐ Sibling ☐ Spouse

☐ Children

Drug abuse:

☐ Father ☐ Mother

☐ Sibling ☐ Spouse

☐ Children

Mental Illness:

☐ Father ☐ Mother

☐ Sibling ☐ Spouse

☐ Children

Lifestyle habits: Please state: how much, how many or how often.

Cigarettes (Packs) _____

Coffee/Tea_____

Alcohol (Type – Per Week) _____

Drugs (Prescription) _____

Over – the – Counter _____

Recreational _____

Vitamins & Herbs _____

Dietary Restrictions _____

Food Cravings _____

Exercise (Type) _____

Other Regular Activities (Reading, TV, Mediation, Ect)

_____

_____

Please check any of the following symptoms experienced in the last 3 months:

General:

Insomnia	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Dreams	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Irritability	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Depression	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Mood Swings	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Fatigue	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Poor Memory	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Fever	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Chills	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Weight Loss	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Weight Gain	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Head & Neck:

Headaches	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Migraines	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Stiff Neck	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Dizziness	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Fainting	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Swollen Glands	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Skin:

Dry Skin	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Bruising Easily	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Rashes	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Itching	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Changes in Moles	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Night Sweating	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Nose/Throat/Mouth:

Nosebleeds	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Sinus Infection	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Dry Nose	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Nasal Congestion	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Sore Throat	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Loss of Voice	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Difficulty Swallowing	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Mouth Sores	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Bleeding Gums	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Dry Mouth	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Thirst	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Eyes:

Blurred Vision	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Floaters	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Burning	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Dry	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Tearing	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Inflammation	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Itchy	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Styes	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Ears:

Earaches	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Ringing	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Hearing Loss	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Infections	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Respiratory:

Chronic Cough	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Coughing Blood/Phlegm	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Difficulty Breathing	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Wheezing/Asthma	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Frequent cold	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Pneumonia / Bronchitis	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Other	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Genito – Urinary:

Pain on Urination	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Frequent Urination	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Blood in Urine	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Cloudy Urination	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Urgency to Urinate	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Unable to Hold Urine	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Other	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Muscles & Joints:

Sore Muscles	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Weak Muscles	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Back Ache	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Back Pain	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Joint Disorders	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Difficulty Walking	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Other	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Male:

Pain/Itching of Genitalia	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Genital Lesions	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Discharges	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Impotence	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Premature Ejaculation	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Weak Urinary Stream	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Lumps on Testicles	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Other	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Cardio – Vascular:

Palpitations	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Chest Pain/ Tightness	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Cold Hands/ Feet	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Swollen Ankles	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Low Blood Pressure	☐ Often	☐ Seldom	☐ Severe	☐ Mild
High Blood Pressure	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Blood Vessel Problems	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Other	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Neurological:

Seizures	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Tremors	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Numbness	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Tingling	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Pain	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Paralysis	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Poor Coordination	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Other	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Gastro – Intestinal:

Poor Appetite	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Excessive Appetite	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Nausea	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Vomiting / Belching	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Indigestion	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Stomach Pain	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Diarrhea	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Constipation	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Blood in the Stool	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Black Stool	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Hemorrhoids	☐ Often	☐ Seldom	☐ Severe	☐ Mild
Other	☐ Often	☐ Seldom	☐ Severe	☐ Mild

Infectious Screening (please check if true):

- ☐ Engage in safe sex
- ☐ HIV risk – self or partner
- ☐ TB risk – self or partner
- ☐ Hepatitis - - self or partner
- ☐ Blood transfusions

Past Medical History (with dates):

Significant Illnesses:

_____
_____
_____

Major hospitalizations:

_____
_____
_____

Significant Traumas (auto accidents, falls, ect…):

_____
_____
_____

History of sexually transmitted diseases (self or partner):

- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Herpes: oral/genital

Please state any other concerns you would like to discuss and what you expect to gain from treatments:

_____
_____
_____
_____

Please Note: Any information submitted using this form is transmitted securely and held in strictest confidence, protecting your privacy.

Name: _____Date: _____