

Welcome

"Our mission is to help our clients build healthy and stress-free lives and safe communities through the delivery of effective and accessible behavioral and mental health care services"

Patient Information

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Race: African American Asian Caucasian Other

Ethnicity: Hispanic Non-Hispanic

Occupation _____

Employer _____

Whom may we thank for referring you?

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

ID # _____

Does Patient Have Additional Insurance? Yes No

Subscriber Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

ID # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Stress Care of New Jersey, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Stress Care of New Jersey, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

Pharmacy Information

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Phone Numbers/Email Address

Cell _____ Email _____

Please be aware that the phone numbers/email provided above will be used for **contacting you, confirming appointments, insurance questions, patient portal access etc** In cases where we do not reach someone, **messages will be left**. If you do not want us to leave voicemail messages, please **do not write that phone number/email above**.

In Case of Emergency, Contact:

Name _____ Relationship _____

Home Phone _____

Work Phone _____

Family History

	Father	Present Health or Cause of Death	Mother	Present Health or Cause of Death	Spouse	Present Health or Cause of Death
Alive	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Deceased	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Brothers	No. Alive	Health			No. Deceased	Cause of Death
Sisters	No. Alive	Health			No. Deceased	Cause of Death
Children	No. Alive	Ages & Health			No. Deceased	Ages & Cause of Death

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES** Diabetes Cancer Bleeding Tendency

Kidney Disease Tuberculosis Heart Disease Stroke High Blood Pressure Nervous Illness Allergy Other

Medical History

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of Sleep
- Loss of Weight
- Numbness
- Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

GASTROINTESTINAL

- Appetite Poor
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive Thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

CARDIOVASCULAR

- Chest Pain
- High/Low Blood Pressure
- Irregular/Rapid Heart Beat
- Poor Circulation
- Swelling of Ankles
- Varicose Veins

EYE, EAR, NOSE, THROAT

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earache/Ear Discharge
- Hay Fever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Persistent Cough
- Ringing in Ears
- Sinus Problems
- Vision – Flashes/Halos

SKIN

- Bruise Easily
- Hives
- Itching/Rash
- Changes in Moles
- Scars
- Sore That Won't Heal

MEN ONLY

- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Sore on Penis
- Other

WOMEN ONLY

- Abnormal Pap Smear
- Bleeding Between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge
- Other

Date of Last Menstrual Period _____

Date of Last Pap Smear _____

Have You Had a Mammogram? _____

Are You Pregnant? _____

Number of Children _____

Check (✓) conditions you have or have had in the past.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |

Describe Serious Illnesses or Operations _____

Medications/Allergies

List Medications You Are Currently Taking

List Allergies to Medications or Substances

Health Habits

HEALTH HABITS Check (✓)

Which substances you use and describe how much you use.

- Caffeine _____
- Drugs _____
- Tobacco User Non-User

If user circle one:

Light (1-9 cigs a day) ; Moderate (10-19) ; Heavy (20-39)

Other

OCCUPATIONAL Check (✓) if your work

exposes you to:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other _____

Signatures - Click here to Acknowledge

I certify by checking the box above and printing my name below that the above information is correct to the best of my knowledge. I will not hold Stress Care of NJ or any staff member responsible for any errors or omissions that I may have made in the completion of this form.

Print Name: _____ Date _____