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?

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 _____

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:_____

Family History

	Father	Present Health or Cause of Death	Mother	Present Health or Cause of Death	Spouse	Present Health or Cause of Death
Alive	☐		☐		☐	
Deceased	☐		☐		☐	

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
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ 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.
- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ 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 _____