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NJ TACC

Patient:

Name _____ Sex ☐ Male ☐ Female

Birth date _____

Was Patient a Multiple Birth ☐ Yes ☐ No

Preferred Language _____

Ethnic Background _____

Race _____

Address _____

Phone numbers

Home _____

Work _____

Cell _____

Other _____

Email Address _____

Would you like to be added to our email distribution list? ☐ Yes ☐ No

Patients primary diagnosis:_____

Decision Making Capacity ☐ Capable ☐ Not Capable ☐ Unsure

Has Guardianship been established ☐ Yes ☐ No Power of Attorney ☐ Yes ☐ No

Healthcare Proxy ☐ Yes ☐ No

Pharmacy Preference (Name, Address, Phone Number) _____

_____

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Next of Kin/Emergency Contacts:

Name ______________________________ Legal Guardian ☐ Yes ☐ No

Date of Birth ______________________ Sex ☐ Male ☐ Female

Same Household ☐ Yes ☐ No

Address ____

Phone ______________________ Relationship ______________________

Email Address ____

Would you like to be added to our email distribution list? ☐ Yes ☐ No

Occupation ____

Notify on admission ☐ Yes ☐ No Authorized Letter Recipient ☐ Yes ☐ No

Language Preference ____________________ Special Needs ☐ Yes ☐ No __________

____

Name ______________________________ Legal Guardian ☐ Yes ☐ No

Date of Birth ______________________ Sex ☐ Male ☐ Female

Same Household ☐ Yes ☐ No

Address ____

Phone ______________________ Relationship ______________________

Email Address ____

Would you like to be added to our email distribution list? ☐ Yes ☐ No

Occupation ____

Notify on admission ☐ Yes ☐ No Authorized Letter Recipient ☐ Yes ☐ No

Language Preference ____________________ Special Needs ☐ Yes ☐ No __________

____

Name ______________________________ Legal Guardian ☐ Yes ☐ No

Date of Birth ______________________ Sex ☐ Male ☐ Female

Same Household ☐ Yes ☐ No

Address ____

Phone ______________________ Relationship ______________________

Email Address ____

Would you like to be added to our email distribution list? ☐ Yes ☐ No

Occupation ____

Notify on admission ☐ Yes ☐ No Authorized Letter Recipient ☐ Yes ☐ No

Language Preference ____________________ Special Needs ☐ Yes ☐ No __________

____

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Guarantor: *(Who is financially responsible?)*

Name _____ Date of Birth:_____

Address _____

Phone _____ Relationship _____

Insurance: *Please attach a copy of the front/back of card if possible*

Insurance Company Name_____

Insurance ID #_____Group #_____

Subscriber name:_____Same as Guarantor ☐ Yes ☐ No

Date of Birth: _____Relationship to patient:_____

Address _____

Phone _____

Employer _____

Secondary Insurance Company Name_____

Insurance ID #_____Group #_____

Subscriber name:_____Same as Guarantor ☐ Yes ☐ No

Date of Birth: _____Relationship to patient:_____

Address _____

Phone _____

Employer _____

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Primary Care Provider:

Name:	**Date of Last Visit:**
Address:	
Phone:	☐ Pediatrician ☐ Adult Physician

Dentist:

Name:	**Date of Last Visit:**
Address:	
Phone:	☐ Pediatric ☐ Adult

Specialists:

Name:	**Specialty**
Address:	**Date of Last Visit:**
Phone:	☐ Pediatric ☐ Adult
Name:	**Specialty:**
Address:	**Date of Last Visit:**
Phone:	☐ Pediatric ☐ Adult
Name:	**Specialty:**
Address:	**Date of Last Visit:**
Phone:	☐ Pediatric ☐ Adult

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Name:	**Specialty:**
Address:	**Date of Last Visit:**
Phone:	☐ Pediatric ☐ Adult

Concerns/reasons for visit:

1.
2.
3.
4.
5.

Medical History

Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

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Visits to the Emergency Room (last 3 years)

Year	Reason	Hospital

List your prescribed medication and over-the-counter drugs, such as vitamins and supplements		
Name the Drug	Strength	Frequency Taken
Allergies		
Name	Reaction You Had	

Past Medical History

Constitutional	☐ Fatigue ☐ Weight gain (amount_____) ☐ Weight loss (amount_____) ☐ Other (describe) **Additional Details:**
Ophthamology	Date of last exam: _____ Diagnosis:_____ ☐ Glasses/contacts ☐ Recent change in vision ☐ Other (describe) **Additional Details:**
Audiology	Date of last exam:_____ ☐ Hearing difficulty ☐ Hearing aids ☐ Recent change in hearing ☐ Other (describe) **Additional Details:**
Cardiac	Date of last exam:_____ Diagnosis:_____ Date of last ECG: _____ Date of last Echo: _____ Date of last Holter: _____ ☐ Congenital Heart Disease ☐ Cardiomyopathy ☐ Arrhythmia (A-Fib, SVT, etc) Type (list):_____ ☐ Hypertension ☐ High cholesterol ☐ Heart Failure ☐ Chest pain ☐ Palpitations ☐ Shortness of breath ☐ Dizziness ☐ Fainting ☐ Swelling in feet/ankles ☐ Pacemaker ☐ AICD (defibrillator)

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	☐ Cardiac catheterization (if yes, date/reason/location) _____ ☐ Other (describe) **Additional Details:**
Respiratory	Date of last exam:_____ Diagnosis:_____ ☐ History of pneumonia or bronchitis ☐ Asthma ☐ Other (describe) ☐ Obstructive Sleep Apnea ☐ CPAP/BiPAP ☐ Chronic Respiratory Insufficiency ☐ Tracheostomy ☐ Cough Assist ☐ Airway Clearance Vest ☐ Cough ☐ Shortness of breath ☐ Snoring ☐ Pauses in breathing **Additional Details:**
Gatrointestinal	Date of last exam:_____ Diagnosis:_____ ☐ Reflux ☐ Inflammatory bowel disease ☐ Irritable bowel syndrome ☐ Celiac Disease ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Coughing/choking with eating or drinking Swallow study date: _____ ☐ Other (describe) ☐ Enteral Feeding ☐ G-tube ☐ J tube ☐ G-J Tube Formula:_____ Schedule:_____ **Additional Details:**
Genitourinary	Date of last exam:_____ ☐ Incontinence ☐ Urine ☐ Stool ☐ Urinary urgency ☐ Hesitancy ☐ Frequency ☐ Other (describe) **Additional Details:**
Musculoskeletal	Date of last exam:_____ ☐ Ambulatory ☐ Non-Ambulatory ☐ Scoliosis ☐ Hip Dislocation ☐ Other (describe) **Additional Details:**
Endocrine	☐ Diabetes ☐ Date/result of last fasting blood sugar/Hemoglobin A1c:_____ ☐ Thyroid disease ☐ Hypothyroid ☐ Hyperthyroid / last TSH: _____ ☐ Change in appetite / thirst (circle) Female: ☐ Menstrual problem ☐ Irregular ☐ Pain ☐ Heavy bleeding ☐ Hygiene concerns ☐ Birth/menstrual control Method:_____ ☐ Other (describe) **Additional Details:**
Heme/Allergy	☐ Bleeding disorder ☐ Anemia ☐ Seasonal allergies ☐ Other (describe) **Additional Details:**
Neurology	☐ Seizures ☐ Stroke ☐ Headaches ☐ Neuropathy (sensation of pins/needles in hands or feet) ☐ Restless legs

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	☐ VP or VA shunt Last revision:_____ ☐ Other (describe) **Additional Details:**
Skin	☐ Eczema / Psoriasis ☐ Other (describe) **Additional Details:**
Psych	☐ Depression ☐ Anxiety ☐ ADHD ☐ Other mental health diagnosis (Bipolar disorder, etc) _____ ☐ Other (describe) **Additional Details:**
Other	**Please list anything we have not asked about that would be important for us to know**

Social History

Living Situation:

☐ Lives with family ☐ Lives alone ☐Group Home ☐Other:_____

Education (current level or highest level completed):

☐ Grade School (grade _____) ☐ Jr. High School (grade _____) ☐ High School (grade _____)

☐ College (year_____) ☐ IEP ☐ 504

Therapies:

☐ Physical Therapy Frequency (times/week) _____ Duration (min) _____

☐ Occupational Therapy Frequency (times/week) _____ Duration (min) _____

☐ Speech Therapy Frequency (times/week) _____ Duration (min) _____

Community Supports:

☐ COSC/DCF(Performcare) ☐ DDD NJ CAT Completed ☐ Yes ☐ No Tier Assigned:_____

Case Manager _____ Phone _____

Support Coordination Agency _____

Support Coodinator _____ _Phone_____

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In Home Support ☐ Yes ☐ No

Number of Hours/Week _____ ☐ Performcare ☐ PPP ☐ DDD

Employed ☐ Yes ☐ No Day Program ☐ Yes ☐ No

Number of Hours/Week _____ Number of Hours/Week _____

Registered with DVR ☐ Yes ☐ No

Receive job coaching services ☐ Yes ☐ No

Does the patient currently receive social security benefits? ☐ Yes ☐ No

Communication Preference/Special Needs:

Expressive Communication(method, device, etc): _____

Receptive Communication Preference ☐ Pictures ☐ Written ☐ Sign Language ☐ Other: _____

Response to Medical Exam: ☐ Cooperative ☐ Resistant ☐ Fearful ☐ Aggressive

Other triggers/sensitivities/precautions: _____

How did you hear about our program_____

Any Additional Details:

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