Integrative Rheumatology Associates, P.C.

Aly Cohen, MD, FACR

601 Ewing Street
Suite B-1
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AlyCohenMD.com

Date of first appointment: ____/____/____ (MONTH / DAY / YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST / FIRST / MIDDLE INITIAL / MAIDEN) Birthdate: ____/____/____ (MONTH / DAY / YEAR)

Address: _____ (STREET / APT#) Age: _____ Sex: ❑ F ❑ M

_____ (CITY / STATE / ZIP) Telephone: Home (____) _____ Work (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____ **Example**

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

_____

_____

_____

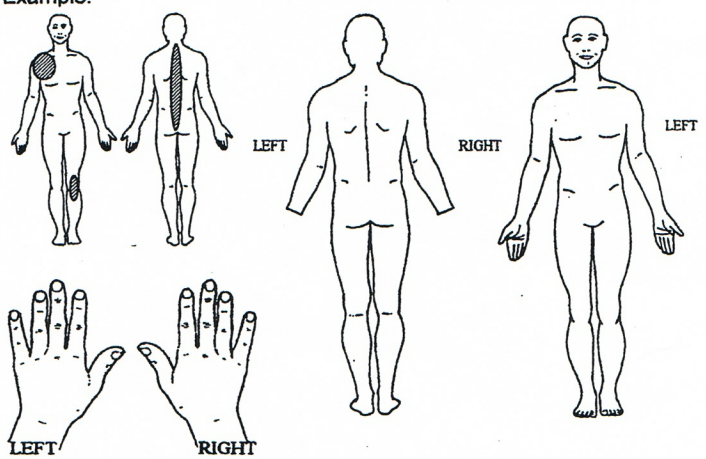
Please list the names of other practitioners you have seen for this problem:

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Name _____ Date _____ Physician Initials _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x–ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ❑ Recent weight gain
  amount _____
- ❑ Recent weight loss
  amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears–Nose–Mouth–Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began:_____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____/

Date of last pap?____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No
If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

Do you snore ☐ yes ☐ No

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever
❑ Bad headaches	❑ Jaundice	❑ Colitis
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness (please list) _____

☐ blood transfusion history

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe: _____

Any other serious injuries? ❑ No ❑ Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

Do you know of any blood relative who has or had: (check and give relationship)

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever _____	❑ Tuberculosis _____
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy _____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism _____	❑ Psoriasis _____	

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Vicodin, Tylenol 3)		❑	❑	❑	
Propoxyphene (Darvon/Darvocet)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❑	❑	❑	
Gold shots (Myochrysine or Solganol)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Penicillamine (Cuprimine or Depen)		❑	❑	❑	
Methotrexate (Rheumatrex)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	
Cyclosporine A (Sandimmune or Neoral)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Prosorba Column		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: _____

_____

_____

_____

_____

Patient's Name _____ Date _____ Physician Initials _____

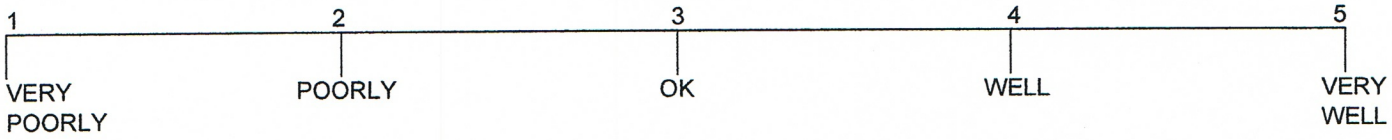
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework?_____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness?	❑	❑	❑
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	❑	❑	❑

What is the hardest thing for you to do?_____

Are you receiving disability? Yes ❑ No ❑

Are you applying for disability? Yes ❑ No ❑

Do you have a medically related lawsuit pending? Yes ❑ No ❑

Patient's Name _____ Date _____ Physician Initials _____

Integrative Rheumatology Associates PC
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601 Ewing Street Suite B-1
Princeton, New Jersey 08540
P: (609) 436 7007 F: (609) 436 7008

_____
Date

I, _____request and give my permission to
Print Patient's Name

release my Medical Record as indicated below from the following Medical Facility:

_____

_____

_____

to **Integrative Rheumatology Associates PC** at the above address or fax number.

☐ Most recent lab reports AND any immune system lab reports, regardless of date

☐ Diagnostic Testing reports, including, but not limited to, X-Rays/MRI/CT of spine and joints
EMG reports and or last bone density report

☐ Progress report from patient's last visit

☐ _____

_____

_____ _____
Patient's signature **Date of Birth**

_____
Witness signature

Integrative Rheumatology Associates PC

Patient Registration Form

Last Name_____ First Name_____ Male Female

Address_____City_____State_____Zip_____-____

Home Phone_____Cell Phone_____Business Phone_____

Email Address_____ Date of Birth_____ Age_____

Social Security #_____ Marital Status _____

The following questions are required by your insurance companies for purpose of data collection only. Please complete:

Race: ☐ American Indian/Alaska ☐ Asian ☐ Black ☐ Caucasian

Ethnicity: ☐ Hispanic ☐Non Hispanic ☐ Decline to answer **Language spoken**:_____

Name, phone number & address of current pharmacy_____

_____

Primary Care Physician_____

Primary Health Insurance	**Secondary or Supplemental Health Insurance**
Insurance Name_____	**Insurance Name**_____
Subscriber Name_____	**Subscriber Name**_____
Date of Birth_____**Relationship**_____	**Date of Birth**_____**Relationship**_____
ID#_____**Group #**_____	**ID#**_____**Group #**_____
Insurance Co Phone Number_____	**Insurance Co Phone Number**_____

How do you wish to be contacted? ☐ **Telephone** ☐ **Email** **If by telephone may we leave messages on your answering machine? Yes No**

Please provide an emergency person and telephone number we can reach on your behalf in an emergency.

_____

Patient Signature_____

Date_____

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CONSENT TO TREAT AND RELEASE OF INFORMATION

The term "health care provider" in this document shall mean **Integrative Rheumatology Associates PC**, its agents and employees, members of the medical staff, their agents and employees and other health care practitioners who provide care to patients.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as:

- Basis for planning my treatment and care.
- Information used to file my claim with the insurance company (diagnosis and procedure).
- Means by which a third-party payer can verify that billed services were actually provided.
- A tool for routine health care operations including assessing quality and reviewing competency of your staff and'/or health care providers.

I understand that I have been provided with the Notice of Privacy that provides more complete information of uses and disclosures. I further state I have been given a copy of the Notice of Privacy prior to signing this consent. I understand that **Integrative Rheumatology Associates PC** reserves the right to change their notice and practices and will provide a copy of the changed form to me prior to treatment. At that time I will be required to sign a new consent before receiving any services. I understand I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment or health care operations and that **Integrative Rheumatology Associates** is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that **Integrative Rheumatology Associates PC** has already taken action on my behalf. Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment testing and procedures as are deemed necessary in the course of my care.

We will disclose your protected health information without your verbal authorization per individual circumstance, only with your written authorization which you may fill in below.

I authorize the release of my protected health information with regard to the minimum necessary policy, to the following individual(s):

_____Relationship_____

_____Relationship_____

RELEASE OF INFORMATION

Information about necessary to substantiate my insurance claims may be released by the health care provider in my care.

FINANCIAL RESPONSIBILITY ASSIGNMENT OF BENEFITS

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health providers are not paid after reasonable notice, that account shall be deemed delinquent and a service can be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

_____Date_____
Signature of patient or responsible party

_____
Print name of signature above (specify relationship if not patient)

Witness_____Title_____Date_____

OSTEOPOROSIS QUESTIONNAIRE

Today.s Date: _____

Name: _____ Referring Physician: _____

Age: _____ SS#: _____ Race: _____

Height: _____ Weight: _____ DOB: _____ Zip Code: _____

Ethnicity: _____ African-American _____ Caucasian _____ Asian _____ Hispanic

Have you previously had DEXA (bone density)? _____YES _____NO

WHERE? _____ WHEN? _____

Are you on hormone replacements (Estrogen)? _____ Duration? _____

Age of menopause? _____ Have you had ovaries removed? _____ Age _____

Have you taken any of the following medications?

_____ Steroids: Dose _____ Duration _____ When: _____

_____ Heparin

_____ Antiseizure Drugs

_____ Thyroid Replacement

Are you on Osteoporosis medication? _____ YES _____NO

_____: Miacalcin _____:Fosamax _____:Estrogens _____:Evista

_____: Actonel _____:Forteo _____:Boniva _____:Reclast

Do you have a history of: _____Hyperthyroidism _____Hyperparathyroidism

_____Cushing.s Disease _____Eating Disorder _____Ulcer Disease ___ celiac disease

Have you had any bone fractures in the past? _____YES _____NO When: _____

Have you had surgery in this year? _____YES _____NO What Type: _____

Do you smoke? _____YES _____NO Number of cigarettes/day _____

Do you drink alcohol? _____YES _____NO Number of drinks/day _____

Do you drink soda? _____YES _____NO Number of sodas/day _____

Do you have a diet LOW in calcium?

_____

Do you take calcium supplements?

_____

Do you have an INACTIVE lifestyle? _____ Do you exercise? _____

Please list activities and frequencies:

_____

_____

Do you have a family history of Osteoporosis?

_____

Have you had a previous fracture? _____ Where? _____

Have you had spine or hip surgery? _____ What type? _____

Have you noticed a decrease in your height? _____ How much? _____

My results should be sent to a Doctor (address):

_____

_____

_____

* Please specify one doctor only. If that doctor referred you here for the bone density, you must call that office to request a copy if you want it to be sent to a second physician.

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Directions to Dr. Cohen's New Office

From the old office in Monroe

- From 312 Applegarth Rd, turn right onto Cranbury-Half Acre Rd for 1.9 miles to the light at route 130
- Cross over US Highway 130 and make a quick left onto Elm Road
- In 200 yards, make a quick right onto Plainsboro Road
- Continue on Plainsboro Road for ~6.5 miles until you approach entrance to US Highway 1 South
- Enter onto US-1 South for 0.9 miles
- Turn right onto Harrison Street and continue straight for 2.5 miles. Along the way you will pass Harrison Shopping Center on your right and will pass though the light at Terhune Street. After crossing Terhune St., keep left and continue through the light at Bunn Drive. (Harrison Street turns into Ewing Street). 601 Ewing will be on the right in approximately 500 yards.

From South Jersey/Philadelphia

- Take I-95 North towards New Jersey
- After crossing into New Jersey, take exit 67 for US Route 1 towards New Brunswick/Trenton
- Stay left for US-1 North towards New Brunswick
- Continue on US-1 North for ~5 miles
- Stay in the right lane after passing Hyatt Regency on right. Just after passing Fisher Street (well visualized), take right lane jug handle to cross over US-1 to Harrison Street
- Cross over US-1 onto Harrison Street and continue straight for 2.5 miles. Along the way you will pass Harrison Shopping Center on your right and will pass though the light at Terhune Street. After crossing Terhune St., keep left and continue through the light at Bunn Drive. (Harrison Street turns into Ewing Street). 601 Ewing will be on the right in approximately 500 yards.

From North Jersey/New York City

- Take NJ Turnpike I-95 South for ~20 miles
- Take exit 9 onto NJ-18 toward US-1, New Brunswick
- Keep right on US-1 South toward Trenton for ~16 miles
- Look for Harrison Street on your right (it will come up quickly after Ruby Tuesdays)
- Turn right onto Harrison Street and continue straight for 2.5 miles. Along the way you will pass Harrison Shopping Center on your right and will pass though the light at Terhune Street. After crossing Terhune St., keep left and continue through the light at Bunn Drive. (Harrison Street turns into Ewing Street). 601 Ewing will be on the right in approximately 500 yards.