ATLANTIC KINEMATICS
Motion and Performance Analysis for Medicine, Law, and Athletes

1707 ATLANTIC AVENUE BUILDING 1 SUITE 3 * MANASQUAN, NEW JERSEY * 08736 * PHONE 732.714.1907 * FAX 732.714.1913 *

Please fill out the following information to the best of your ability.
Please print legibly with a blue or black ink pen.

PERSONAL INFORMATION

Name: _____ **Phone #:** _____

Street Address: _____ **City:** _____

State: _____ **Zip code:** _____

Social Security #: ____-_____-_____ **Date of Birth:** ___/___/___ **Date of Injury:** ___/___/___

Height: _____ **Weight:** _____ **Age:** _____ **Handedness: R or L**

Please describe how you were injured in the space provided below.

_____

_____

_____

_____

Do you have or anticipate attorney representation for this injury? _____ If yes, what is their name: _____

_____

MEDICAL INFORMATION

What is the date of your next scheduled appointment with your treating physician? ___/___/___

Please list the Physician(s) that you have seen and the treatments that they have provided in the table below.

Physician's Name/ Facility/ Practice	Provided Treatments or Surgery

Job Information

Job Title: _____ Employer: _____

Supervisor: _____ Work Phone #: _____

Are you currently employed? Yes or No If yes, are you currently (please circle one below):

- **Working modified/light duty.** Please specify the work restrictions.
  - _____
  - _____
- **Working Full duty**
- **Not currently working, but still employed**

Please fill out the following information according to your Full Duty Job Specifications.

List the heaviest item(s) you are required to lift without the aid of another person or device?

_____

_____

How much does that item(s) weigh? _____

How many times does the item(s) have to be lifted, on average, each day? _____

Please fill out the chart below according to the actions that are required to do your job. It is understood that not all occupations require the same activities each day. Please place an "X" in the area that corresponds with the cumulative amount of time your job requires you to perform that action in one day.

Activity	Not at All	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Standing				
Sitting				
Walking				
Driving				
Climbing				
Balancing				
Bending/Stooping				
Kneeling				
Crouching				
Crawling				
Pushing/Pulling				
Squatting				
Reaching Above Shoulder				
Gripping				

On the reverse of this sheet, please describe your full duty job responsibilities.

Thank you for your time and consideration. We look forward to working with you.

I hereby confirm that the above information is correct.

_____ _____

Examinee / Legally Authorized Individuals Signature DATE

_____ _____

Print Name If Signed On Behalf Of The Examinee RELATIONSHIP (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE, ETC.)

PLEASE COMPLETE THE FOLLOWING FORM **TO ALLOW KINEMATIC CONSULTANTS INC TO OBTAIN** A COPY OF YOUR RELEVANT HEALTH INFORMATION.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please print legibly with a blue or black ink pen.
Fill in applicable highlighted areas

EXAMINEE NAME:
DATE OF BIRTH:

I. MY AUTHORIZATION

I HEREBY AUTHORIZE:

NAME (OR TITLE) AND ORGANIZATION:
(NAME OF PHYSICIAN'S OFFICE / MEDICAL PRACTICE DISCLOSING INFORMATION)

ADDRESS:
CITY: STATE: ZIP:
PHONE NO.: FAX NO.:

TO USE OR DISCLOSE THE FOLLOWING HEALTH CARE INFORMATION *(CHECK ALL THAT APPLY):*

	ALL HEALTH INFORMATION MAINTAINED
X	HEALTH INFORMATION RELATING TO THE FOLLOWING TREATMENT OR CONDITION:
	HEALTH INFORMATION FOR THE DATE (S):
	OTHER (SPECIFIC DESCRIPTION):

TO THE BELOW NAMED PRACTICE:

NAME (OR TITLE) AND ORGANIZATION: **KINEMATIC CONSULTANTS, INC**
(NAME OF PHYSICIAN'S OFFICE / MEDICAL PRACTICE DISCLOSING INFORMATION)

ADDRESS: **1707 ATLANTIC AVENUE, BUILDING 1, SUITE 3**
CITY: **MANASQUAN** STATE: **NJ** ZIP: **08736**
PHONE NO.: **732-714-1907** FAX NO.: **732-714-1913**

REASON(S) FOR THIS AUTHORIZATION:

X	AT MY REQUEST
	OTHER (SPECIFY):

THIS AUTHORIZATION WILL EXPIRE IN SIX (6) MONTHS OR ON THE FOLLOWING DATE:

II. My Rights

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure or information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I don't need to sign this authorization to assure treatment. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, or genetics: **IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL. DO NOT RELEASE:**

Examinee / Legally Authorized Individuals Signature — DATE

Print Name If Signed On Behalf Of The Examinee — RELATIONSHIP (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE, ETC.)