EMAIL _____ DATE _____

LAST NAME _____ FIRST NAME _____ MI _____

(Please Check) ODr OMr OMs OMrs OMiss OJR OSR **Prefers to be called** _____

ADDRESS _____ CITY _____ ZIP CODE _____

For proper identification in our computer system, please provide the following information. Your social security number is protected by HIPPA.

SOCIAL SECURITY # _____ **DATE OF BIRTH** _____

(Please Check)

GENDER IDENTITY OMale OFemale OOther_____ **SEXUAL ORIENTATION** _____
RACE OBlack OWhite ONative American OHispanic OBi-racial OOther_____
ETHNICITY OHispanic ONon-Hispanic OOther_____
LANGUAGE OEnglish OOther_____
MARITAL STATUS OMarried OSingle ODivorced OWidowed OLegally Separated

PHONE NUMBERS (Please check primary phone number)

O**HOME#** _____ O**DIRECT WORK#** _____ O**CELL#** _____

REFERRING DOCTOR _____ **PHONE#** _____

PRIMARY CARE DOCTOR(FAMILY DOCTOR) _____ **PHONE#** _____

EMPLOYER _____ **MAIN PHONE #** _____

EMPLOYER ADDRESS _____ **CITY** _____ **ZIP CODE** _____

ACCIDENT INFORMATION **Date of Accident**_____ **State Accident Occurred**_____

OWORK Claim is: ODenied O Open **OAUTO** Benefits are: OAvailable OExhausted
Is your case in Litigation? OYes ONo If yes, please provide Attorney and/or case manager information:

ATTORNEY NAME _____ **CASE MANAGER NAME** _____

PHONE NUMBER _____ **PHONE NUMBER** _____

FAX NUMBER _____ **FAX NUMBER** _____

INSURANCE INFORMATION: If you are NOT the subscriber of your insurance plan provide the following:
LAST NAME _____ **FIRST NAME** _____ **MI** _____

RELATIONSHIP TO THE PATIENT _____

PHONE NUMBER _____ **DATE OF BIRTH** _____

EMPLOYER _____ **EMPLOYER PHONE NUMBER** _____

How would you like to be contacted? PLEASE CHECK ONE ONLY

OHome phone, ok to leave message for call back.
OHome, no message.
OWork Phone, ok to leave message for call back.
OWork, no message.
OCell phone, ok to leave message for call back
OCell, no message
OPatient portal (email)
OPatient declined

ASSOCIATES IN PHYSICAL MEDICINE & REHABILITATION OF SW PA PC

Consent to Disclosure of Personal Health Information to *Family Members*

I, _____, give my permission to the practitioners and staff of Associates in P M & R to *release* information regarding my medical care, including my medical condition, test results, appointment dates/times and to *obtain* information in order to satisfy any outstanding balance to the following ***FAMILY MEMBERS***:

Name	Relationship	Telephone Number
Emergency Contact:		
Other family members who have permission to discuss your care:		

_____ _____

Signature of patient (or personal representative) Date

Personal Representative Name:_____

Relationship/Authority: _____

Associates in Physical Medicine and Rehabilitation of SW PA PC

Acknowledgement of Receipt of Notice of Privacy Practices/Consent to Treat

Associates in PM&R of SW PA PC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to Contact our Privacy Officer:

Mail:	Associates in Physical Medicine & Rehabilitation of PW PA PC Attention, Privacy Officer 101 Trich Drive, Suite 2 Washington, Pennsylvania 15301
Telephone:	724-223-9270, extension 11
Fax:	724-223-8133

Acknowledgement of Receipt and Consent

I, _____, give my consent to the practitioners of Associates in PM &R to perform medical services determined to be necessary or advisable for the benefit of my health care. I acknowledge that I have received the Notice of Privacy Practices for Associates in PM&R and they are authorized to use and disclose my protected health information for treatment, payment and health care operations purposes consistent with its Notice of Privacy Practices.

Medicare, Medicaid and all other(Third Party Payors) Certification

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of any protected health information about me to release to the Centers for Medicare and Medicaid or its intermediaries or third party payors, any information needed for this or a related insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or organization to submit a claim to the insurance carrier for payment to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or personal representative) Date

Personal Representative Name: _____

(If patient is unable to sign)

Relationship/Authority: _____

Good Faith Efforts to Obtain Acknowledgement of Receipt

The above named patient/personal representative was offered the Notice of Privacy Practices.
Describe how notice was provided:

- ☐ Offered copy and individual refused to accept delivery
- ☐ Offered copy and individual accepted delivery
- ☐ Other: _____

Describe efforts to obtain signature on acknowledgement of notice form:

- ☐ Patient/personal representative was asked to sign form and refused
- ☐ Other: _____

_____ _____

Signature of staff member Date

Check all problems that apply to you today:

☐ Neck pain	☐ Right arm pain	☐ Left arm pain
☐ Back pain	☐ Right leg pain	☐ Left leg pain
☐ Difficulty walking	☐ Numbness	☐ Muscle Twitching

Other: _____

Mark these drawings according to where you hurt. Please indicate sensations you feel by referring to the key below.

KEY

///////	Stabbing
XXXXX	Burning
00000	Numbness
=====	Pins & Needles
++++++	Aching

PAIN LEVEL

0 No pain

1 Mild pain; you are aware of it but it doesn't bother you

2 Moderate pain that you can tolerate without medicine

3 Moderate pain that requires medication to tolerate

4-5 More severe pain; you begin to feel antisocial

6 Severe pain

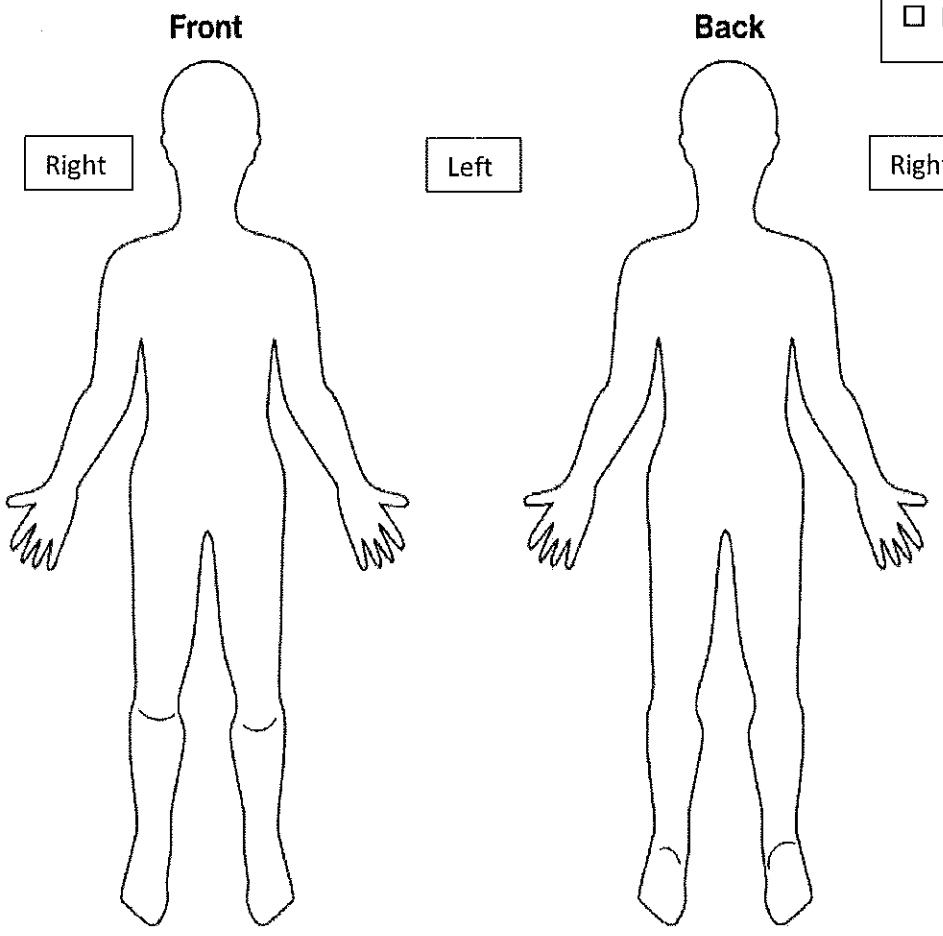
7-9 Intensely severe pain

10 Most severe pain; it may make you contemplate suicide

Pain Diagram

☐ RIGHT HANDED

☐ LEFT HANDED



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

WHAT IS YOUR PAIN LEVEL AT ITS WORST? (0-10) _____

Name: _____ Date of Birth: _____ Date : _____

What makes your pain better? _____

What makes your pain worse? _____

Have you had?

Physical Therapy ☐ yes ☐ no if YES, name of facility _____

Chiropractic Care ☐ yes ☐ no if YES, name of facility _____

Diabetic Foot Exam ☐ yes ☐ no if YES, name of facility _____ Date: _____ A1C: _____

MEDICATION LIST *****PLEASE PROVIDE LIST TO THE STAFF*****

Name	Dose	Frequency	Prescribing Doctor
1.			
2.			
3.			
4.			
5.			

ALLERGIES ☐ **No Known DRUG Allergies** ☐ **No Known Non Drug Allergies**

Medication(s) ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ NSAIDS ☐ IVP Dye

Other Medications _____

Other ☐ Tape ☐ Latex ☐ Seasonal **Food** ☐ Shellfish ☐ Gluten

Any other: _____

HABITS **Smoking Status** ☐ Never smoked ☐ Everyday smoker ☐ Some day smoker ☐ Former smoker

If smoker please circle: Cigarette / Cigar / E-Cigarette or Vape #_____pack(s) cigarette(s) per day

Smokeless Tobacco Status ☐ Never ☐ Everyday ☐ Former **Please circle:** Snuff / Tobacco

ALCOHOL CONSUMPTION ☐ Non-drinker # of drinks per day_____ # of drinks per week_____

☐ Former drinker

SURGICAL HISTORY			**DATE**
Knee Replacement	☐ Left	☐ Right	
Knee Arthroscope	☐ Left	☐ Right	
Hip Replacement	☐ Left	☐ Right	
Hysterectomy			
Tubal Ligation			
C-Section			
Tonsillectomy			
Bone Fracture Repair			
Prostate Resection (TURP)			

Name: _____ Date of Birth: _____ Date: _____

SURGICAL HISTORY continued	DATE
Thyroid Removal	
Appendectomy (appendix)	
Cholecystectomy (gallbladder)	
Coronary Artery Bypass Grafting (GABG)/heart bypass	
Posterior Cervical Fusion (neck surgery through the back)	
Discectomy Cervical (surgery for disc herniation in neck, through the front)	
Fusion Lumbar (low back fusion)	
Discectomy Lumbar (surgery for disc herniation low back)	
Rotator Cuff Repair	
List other surgeries:	

MEDICAL HISTORY **Check all problems that apply to you NOW or in the PAST.**

Heart Conditions	Yes	No	Neurological Conditions	Yes	No
Coronary Artery Disease			Depression		
Irregular Heartbeat			Anxiety		
Valve problem/replacement			Bipolar Disorder		
Heart Attack			Panic Attacks		
Angina			Stroke/CVA		
High Blood Pressure			Headache		
Lung/Breathing Conditions	**Yes**	**No**	Drug Dependence		
Asthma			Alcohol Dependence		
Bronchitis			Seizure Disorder/Epilepsy		
COPD			**Endocrine Conditions**	**Yes**	**No**
Lung Cancer			Diabetes		
Eyes/Ears/Nose/Throat	**Yes**	**No**	Thyroid Disease		
Glaucoma			Breast Cancer		
Cataracts			Last Menstrual Period (if applicable)		
Sinusitis			**GI/Digestive System**	**Yes**	**No**
Laryngitis			Ulcer Disease		
TMJ Syndrome			Crohn's Disease		
Hearing Loss			Irritable Bowel Syndrome (IBS)		
Genito-Urinary System	**Yes**	**No**	Ulcerative Colitis		
Kidney Stone			GI Bleeding		
Prostate Cancer			Hepatitis		
BHP-Benign Prostatic Hypertrophy			Cirrhosis		
Chronic Kidney Disease:			GERD		
Stage: I II III IV V			Hemorrhoids		
			Colon Cancer		

Other Medical Problems: _____

Name: _____ Date of Birth: _____ Date: _____

SOCIAL HISTORY *Check all situations that apply to you.*

Employment

☐ Full time ☐ Part time ☐ Disabled

☐ Retired

☐ Unemployed ☐ Laid off

☐ Unable to work due to pain

Student

☐ Full Time ☐ Part time

☐ Unable to attend school due to pain

Special Living Arraignments

☐ Assisted Living Facility

☐ Living Temporarily

(at shelter or mission, with friends, or half way house)

☐ Skilled Nursing Facility

Martial/Child Status

☐ Married ☐ Single

☐ With children ☐ No children

☐ Pregnant- # of months: _____

FAMILY HISTORY *List any medical history which applies to your **immediate family.***

_____

_____

Have you had any of the following symptoms over the past three months?

	Yes	No		Yes	No
Weight loss more than 10 lbs.			Diarrhea		
Weight gain more than 10 lbs.			Constipation		
Fevers or chills			Loss of bowel control/incontinence)		
Night sweats			Blurry vision		
Loss of appetite			Double vision		
Skin rashes			Loss of vision		
Easy bruising			Burning on urination		
Sore throat			Bleeding on urination		
Hearing loss			Loss of bladder control/incontinence)		
Ringing in ears			Missed most recent menstrual period		
Shortness of breath at rest			Loss of memory/confusion		
Shortness of breath with exercise			Weakness		
Coughing			Seizures or convulsions		
Chest pain			Dizziness or lightheaded		
Heart racing, palpitations			Passing out episodes		
Swelling of the ankles			Feelings of depression or sadness		
Stomach pain			Stress increases pain		
Nausea			Difficulty sleeping		
Vomiting			Increased irritability		

Name: _____ Date of Birth: _____ Date: _____