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)

OHOME# _____ ODIRECT WORK# _____ OCELL# _____

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/time and to obtain information in order to satisfy any outstanding balance to the following FAMILY MEMEBERS:

NAME	RELATIONSHIP	TELEPHONE NUMBER	Please ✓
		Home: Cell: Work:	☐ Emergency Contact ☐ Family Member ☐ Friend
		Home: Cell: Work:	☐ Emergency Contact ☐ Family Member ☐ Friend

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

Associates in PM&R of SWPA 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 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 and Rehabilitation of SW PA PC
101 Trich Drive, Suite 2, Washington, PA 15301
Telephone: 724-223-9270 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. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Good Faith Effort to Obtain Acknowledgement of Receipt

The above names 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

_____ _____
Initials of Staff Member Date

_____ _____
Signature of patient (or personal representative) Date

Personal representative Name:_____Relationship to patient_____

Check all problems that apply to you today:

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

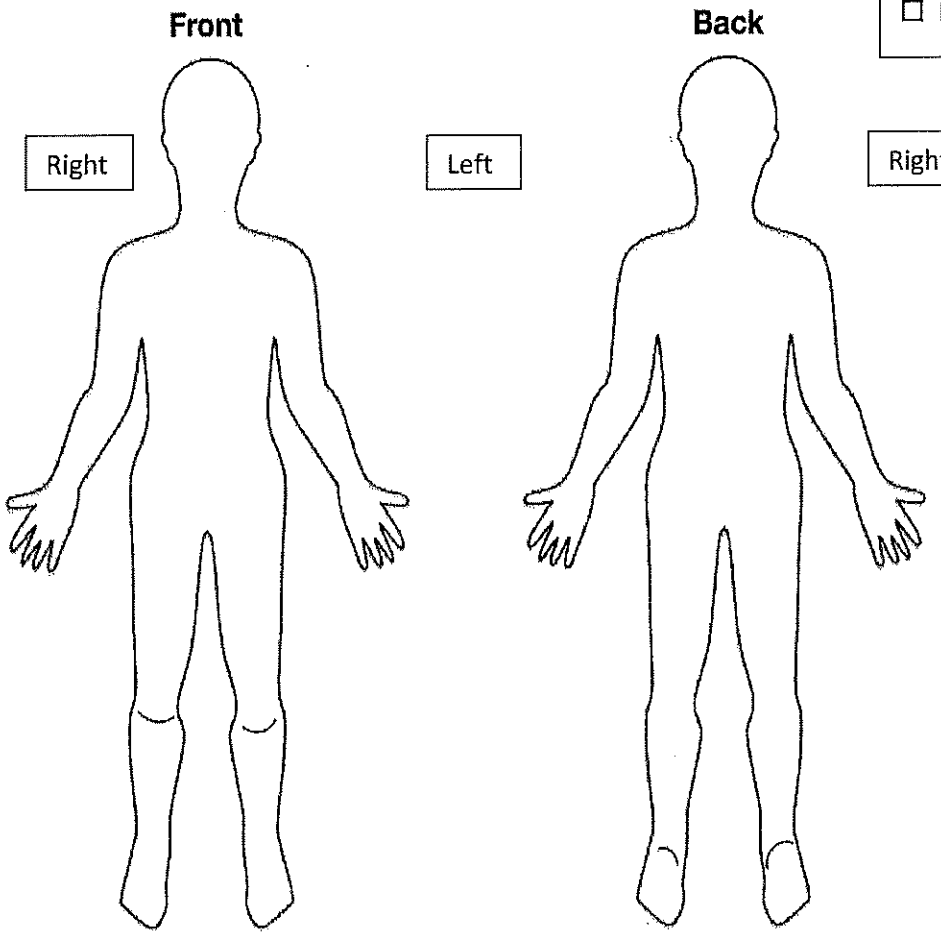
6 Severe pain

7-9 Intensely severe pain

10 Most severe pain; it may make you contemplate suicide

Pain Diagram

☐ RIGHT HANDED
☐ LEFT HANDED



www.despitepain.com

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 : _____

Have you had?

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

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

What makes your pain better? _____ 2

What makes your pain worse? _____

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

Medication Name	Dosage	Frequency	Prescribing Doctor
1.			
2.			
3.			
4.			
5.			

ALLERGIES ☐ No Known **DRUG** Allergies ☐ No Known **NON DRUG** Allergies

Drug(s) Allergies: ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ NSAIDS ☐ IVP Dye

Other Medications _____

Non Drug Allergies: ☐ Tape ☐ Latex ☐ Seasonal FOOD: ☐ Shellfish ☐ Gluten

Any other Non Drug Allergies: _____

HABITS **Smoking Status:** ☐ Never Smoked ☐ Everyday Smoker ☐ Some Day Smoker ☐ Former Smoker

If smoker please circle: Cigarette / Cigar / E-Cigarettes 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 List area of repair:			
Prostate Resection (TURP)			

Name:_____ Date of Birth:_____ Date:_____

SURGICAL HISTORY CONTINUTED	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 Lumber (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**
Coronary Artery Disease I25.10		
Irregular Heartbeat R00.8		
Valve problem/replacement Z95.5		
Heart Attack: **CURRENT** I21.9 **OLD** I25.2		
Angina I20.9		
High Blood Pressure I10		
Lung/Breathing Conditions	**YES**	**NO**
Asthma: **Unspecified** J45.909 **Moderate** J45.40 **Severe** J45.50		
Bronchitis: **Unspecified** J40 **Acute** J20.9 **Severe** J42		
COPD J44.9		
Lung Cancer: **Unspecified** C34.90 **Left** C34.92 **Right** C34.91		
Eyes/Ears/Nose/Throat	**YES**	**NO**
Glaucom: **Unspec.** H40.9 **LT** H40.832 **RT** H40.831 **BILAT** H40.833		
Cataracts: **Unspecified** H26.9 **Diabetic Cataracts** E11.36		
Sinusitis: **Acute** J01.90 **Chronic** J32.9		
Laryngitis: **Acute** J04.0 **Chronic** J37.0		
TMJ: **Unspec** M26.629 **LT** M26.622 **RT** M26.261 **BILAT** M26.263		
Hearing Loss: **Unspec** H91.90 **LT** H91.92 **RT** H91.91 **BILAT** H91.93		
Genito-Urinary System	**YES**	**NO**
Kidney Stone N20.0		
Prostate Cancer C61		
BHP-Benign Prostatic Hypertrophy: With Lower Urinary Tract N40.1 Without N40.0		
Chronic Kidney Disease: **Unspecified** N18.9		
Stage I N18.1 **II** N18.2 **III** N18.3 **IV** N18.4 **V** N18.5		

Neurological Conditions	**YES**	**NO**
Depression **Unspecified** F32.A		
Anxiety F41.9		
Bipolar Disorder F31.9		
Panic Attacks F41.0		
Stroke/CVA I63.9		
Headache R51.9		
Drug Dependence F19.20		
Alcohol Dependence F10.20		
Seizure Disorder/Epilepsy G40.309		
Endocrine Conditions	**YES**	**NO**
Diabetes: **Type 1** E10.9 **Type 2** E11.9 **Type 2 w/compl** E11.8		
Thyroid Disease: **Unspec** E07.9 **Hypo** E03.9 **Hyper** E05.90		
Breast Cancer: Unspecified C50.919 LT C50.912 RT C50.911		
Last Menstrual Period (if applicable)		
GI/Digestive System	**YES**	**NO**
Ulcer Disease K27.9		
Crohn's Disease: With Complications K50.919 W/O K50.90		
Irritable Bowel Syndrome (IBS): **With Diarrhea** K58.0 **W/O Diarrhea** K50.90		
Ulcerative Colitis: **With Compl** K51.919 **W/O Compl** K51.90		
GI Bleeding: **Unspecified** K92.9		
Hepatitis: **Unspecified** K75.9		
Cirrhosis: **Unspecified** K74.60		
GERD: **Unspecified** K21.9 **W/Bleeding** K21.01 **W/O** K21.00		
Hemorrhoids: **Unspecified** K64.9	**YES**	**NO**
Colon Cancer: Unspecified C18.19	**YES**	**NO**

Name:_____ Date of Birth:_____ Date:_____

Other Medical Problems:_____

_____

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 Arrangements

☐ Assisted Living Facility

☐ Living Temporarily

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

☐ Skilled Nursing Facility

Marital/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		