EMAIL _____ **DATE** _____

LAST NAME _____ **FIRST NAME** _____ **MI** _____

(Please Check) ○Dr ○Mr ○Ms ○Mrs ○Miss ○JR ○SR **Prefers to be called** _____

ADDRESS _____ **CITY** _____ STATE **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 ○Male ○Female ○Other_____ **SEXUAL ORIENTATION** _____
RACE ○Black ○White ○Native American ○Hispanic ○Bi-racial ○Other_____
ETHNICITY ○Hispanic ○Non-Hispanic ○Other_____
LANGUAGE ○English ○Other_____
MARITAL STATUS ○Married ○Single ○Divorced ○Widowed ○Legally Separated

PHONE NUMBERS (Please check primary phone number)

○**HOME#** _____ ○**DIRECT WORK#** _____ ○**CELL#** _____

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

EMPLOYER _____ **MAIN PHONE #** _____

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

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

○Home phone, ok to leave message for call back.
○Home, no message.
○Work Phone, ok to leave message for call back.
○Work, no message.
○Cell phone, ok to leave message for call back
○Cell, no message
○Patient portal (email)
○Patient declined

Consent to Disclosure of Personal Health Information to Family Members

I, _____, give my permission to the practitioners and staff 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

LAST NAME: _____ **FIRST NAME:** _____ **DATE:** _____

Consent for Treatment

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.

Permission to bill your insurance company

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.

PLEASE SIGN AND DATE BELOW ACCEPTING CONSENT FOR TREATMENT ,PERMISSION TO BILL INSURANCE COMPANY OR TO SET UP PERSONAL PAYMENT ARRANGEMENT

_____

Signature of patient *(or personal representative)* **(PLEASE PRINT NAME)** **Date**

*Personal representative Name:*_____*Relationship to patient:*_____

_____

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

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

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: _____ **RATE YOUR CURRENT PAIN LEVEL? (0 – 10)** _____

(10 BEING HIGHEST LEVEL OF PAIN)

Have you had any of the following for the problem you are being seen for today?

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

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

What makes your pain better? _____

What makes your pain worse? _____

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

Medication Name/Dosage	Number of Tablets/Capsules/Patch/Film/Units	Prescribing Doctor
1.	#_____ Per: ¨ Day ¨ Week ¨ Month ¨ Year	
2.	#_____ Per: ¨ Day ¨ Week ¨ Month ¨ Year	
3.	#_____ Per: ¨ Day ¨ Week ¨ Month ¨ Year	
4.	#_____ Per: ¨ Day ¨ Week ¨ Month ¨ Year+	
5.	#_____ Per: ¨ Day ¨ Week ¨ Month ¨ Year	
6.	#_____ Per: ¨ Day ¨ Week ¨ Month ¨ Year	
7.	#_____ Per: ¨ Day ¨ Week ¨ Month ¨ Year	
8.	#_____ Per: ¨ Day ¨ Week ¨ Month ¨ Year	

ALLERGIES

DRUG ALLERGIES:	¨ Penicillin	¨ Codeine	¨ Sulfa	¨ NSAIDS	¨ IVP Dye
OTHER DRUG ALLERGIES:	¨	¨	¨	¨	¨
NON DRUG ALLERGIES:	¨ Tape	¨ Latex	¨ Seasonal	¨ Shellfish	¨ Gluten
OTHER NON DRUG ALLERGIES:	¨	¨	¨	¨	¨

HABITS

SMOKING STATUS:	¨ Never Smoked	¨ Everyday Smoker	¨ Some Day Smoker	¨ Former Smoker
Please check:	¨ Cigarette	¨ Cigar	¨ E-Cigarette/Vape	Packs per Day:
SMOKELESS TOBACCO	¨ Never	¨ Everyday	¨ Former	Circle: Snuff / Tobacco
ALCOHOL CONSUMPTION	¨ Non-Drinker	¨ Former Drinker		
Number of Drinks:	Per Day _____	Per Week _____	Per Month _____	Per Year: _____

Name:_____Date of Birth:_____Date:_____

SURGICAL HISTORY

	DATE		DATE
Knee Replacement ¨ Left ¨ Right		*Thyroid Removal*	
Knee Arthroscope ¨ Left ¨ Right		*Appendectomy (Appendix)*	
Hip Replacement ¨ Left ¨ Right		*Cholecystectomy (Gallbladder)*	
Shoulder Replacement ¨ Left ¨ Right		*Coronary Artery Bypass (CABG)/heart bypass* *# of Vessells if known:*_____	
Carpal Tunnel Release ¨ Left ¨ Right		Pacemaker Placement	
Cubital Tunnell Release ¨ Left ¨ Right (moving ulnar nerve at elbow)		Cardiac Ablation	
Cataract Surgery ¨ Left ¨ Right ¨ Both		*Stent Placement:* **Heart**: # Stents _____ **Leg**: # stents_____	
Removal of Tumor/Cyst (list area) _____		Gastric Bypass: List Type:_____	
Hysterectomy		*Posterior Cervical Fusion(neck, through the back)*	
Tubal Ligation		*Anterior Cervical (neck, through the front)*	
C-Section		*Fusion Lumbar (low back fusion)*	
Tonsillectomy		*Discectomy Lumbar(surgery for low back disc herniation)*	
Surgical Bone Fracture Repair List area of surgery:		Lumber Laminectomy	
Prostate Resection (TURP)		*Rotator Cuff Repair* ¨ Left ¨ Right	
Amputation:_____ _____ _____		**List other surgeries: _____**	

Name:_____Date of Birth:_____Date:_____

Check all problems that apply to you NOW or in the PAST

MEDICAL HISTORY

Coronary Artery Disease	I25.10		Depression	F32.A	
Irregular Heartbeat	R00.8		Anxiety	F41.9	
Valve problem/replacement	Z95.5		Bipolar Disorder	F31.9	
Heart Attack	I25.2		Panic Attacks	F41.0	
Angina	I20.9		Stroke/CVA TIA/Mini Stroke	I63.9 G459	
High Blood Pressure	I10		Headache	R51.9	
Asthma:	J45.909		Drug Dependence	F19.20	
Bronchitis:	J40		Alcohol Dependence	F10.20	
COPD	J44.9		Seizure Disorder/Epilepsy	G40.309	
Lung Cancer: Unspecified Left Right C34.90 C34.92 C34.91			Diabetes: Pre-Diabetes Type 1 Type 2 R73.03 E10.9 E11.8		
Glaucoma:	H40.9		Thyroid Disease: Unspec Hypo Hyper E07.9 E03.9 E05.90		
Cataracts:	H26.9		Breast Cancer: Unspecified LT RT C50.919 C50.912 C50.911		
Sinusitis:	J32.9		Last Menstrual Period (if applicable)		
Laryngitis:	J37.0		Ulcer Disease Crohn's Disease:	K27.9 K50.919	
TMJ:	M26.629		Irritable Bowel Syndrome (IBS): With Diarrhea K58.0 W/O Diarrhea K58.9		
Hearing Loss: LT RT BILAT H91.92 H91.91 H91.93			Ulcerative Colitis:	K51.919	
Kidney Stone	N20.0		GI Bleeding: Unspecified	K92.2	
Prostate Cancer	C61		Hepatitis: A (B15.9) B (B19.10) C (B19.20)		
BPH-Benign Prostatic Hypertrophy:	N40.1		Cirrhosis:	K74.60	
Chronic Kidney Disease: Unspecified N18.9 Stage: 1 2 3 4 5 N18.1 N18.2 N18.3 N18.4 18.5			GERD:	K21.9	
END STAGE KIDNEY DISEASE	N18.6		Hemorrhoids	K64.9	
			Colon Cancer	C18.9	

Other Medical Problems:_____

_____

Name:_____**Date of Birth:**_____**Date:**_____

SOCIAL HISTORY

Employment

¨ Full Time ¨ Part Time ¨ Disabled ¨ Homemaker

¨ Retired ¨ Unemployed ¨ Unable to work due to pain

Student

¨ Full Time ¨ Part Time

¨ Unable to attend school due to pain

Current Living Arrangements:_____
(where do you live?)

Marital/Child Status

¨ Married ¨ Single

¨ With Children ¨ No Children

¨ Pregnant-# of Months_____

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

Mother: _____
Father: _____
Siblings: _____
Grandfather: _____
Grandmother:_____

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

CHECK ALL THAT APPLY TO YOU:	✓		✓
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	