ALL POINTS
PHYSICAL MEDICINE • REHABILITATION • FITNESS

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PATIENT INFORMATION

Patient's First Name: M.I. Last:	□ Mr. □ Mrs. □ Miss □ Ms.	Marital status: (circle one) Single / Married / Divorced Separated / Widowed

Is this your legal name? □ Yes □ No	If not, what is your legal name?	Social Security #	Birth Date: / /	Age:	Sex: □ M □ F

Street Address:	City:	State:	Zip Code:

Home phone # ( )	Cell phone # ( )	Employer phone # ( )

How did you hear about our practice?

Employer:	Occupation:
Emergency Contact Name / Relationship:	Emergency Contact Phone # ( )

Email:

Family Physician:	Referring Physician:

THE FOLLOWING QUESTIONS MUST BE ANSWERED BEFORE SEEING THE DOCTOR.

Are you currently receiving treatment through hospice program? □ Yes □ No Start date: _____ Provider: _____

Are you currently receiving home health services for any reason? □ Yes □ No Start date: _____ Provider:_____

****Are you seeing us today due to an auto accident? □ Yes □ No Date of accident: _____**

****Are you seeing us today due to a work-related injury? □ Yes □ No Date of injury: _____**

****If yes, please see receptionist for additional paperwork**

INSURANCE INFORMATION

Copays for all services are due at time of service.
Please give your insurance card(s), copay, and photo ID to the receptionist with completed paperwork.

Primary Insurance Company:	ID #	Group #	Specialist Co-Payment: $
Primary Insurance Insured's Name:	**Insured's Birthdate: (mandatory)** / /	Insured's Social Security #	Relationship: □ Self □ Child □ Spouse □ Other _____
Secondary Insurance Company:	ID #	Group #	
Secondary Insurance Insured's Name:	**Insured's Birthdate: (mandatory)** / /	Insured's Social Security #	Relationship: □ Self □ Child □ Spouse □ Other _____

AUTHORIZATION: I hereby authorize PM&R North, Inc./All Points Physical Medicine to release any information concerning my illness and treatments, and that of my dependents. I also authorize payment of medical benefits to PM&R North, Inc. for services rendered. I understand that payment for services is my obligation regardless of insurance or third party involvement in accordance with the payment policy set forth by PM&R North, Inc./All Points Physical Medicine. This authorization applies for future services.

_____ _____

Patient/Guardian Signature Date

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Name:_____ D.O.B.: _____ Date: _____

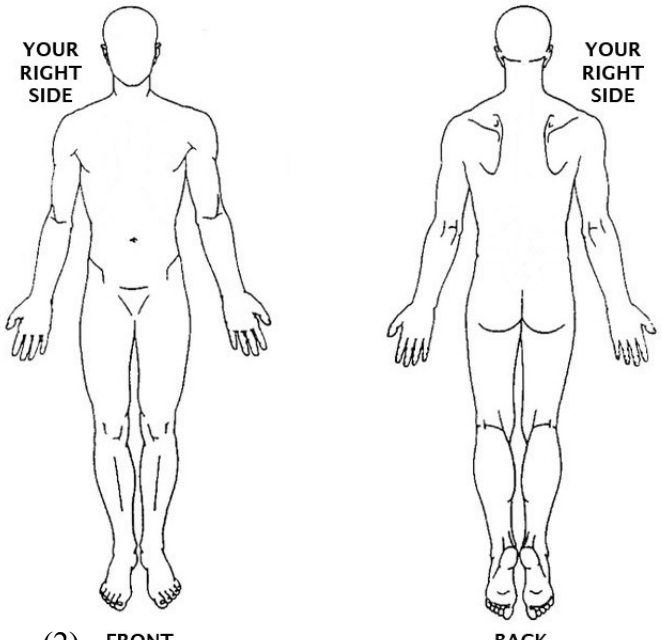
Explanation of illness/injury:

1. How long have you had this pain/problem? _____
2. Where did it happen? _____
3. How did it happen? _____
4. Have any daily activities been affected from your illness/injury? (ex: sleeping, eating, bathing, dressing, getting out of bed, etc.) _____
5. Please describe your pain by checking all that apply:
   □ Sharp □ Burning □ Achy □ Deep □ Knife-like □ Twisting □ Pressure □ Heavy □ Gnawing
6. On a scale of 1 - 10, how severe is your pain? ("**1**" very little or no pain, "**10**" agonizing pain): _____
7. How would you describe your pain? □ Constant □ Intermittent
8. What makes your pain worse? _____
9. What makes your pain better? _____
10. Have you tried any medications to help relieve the pain? □ Yes □ No
    If yes, which medication? When did you take it? _____
11. Have you had any recent X-rays, CT, MRI? _____ If so, what facility?_____
12. Have you had any recent physical therapy or chiropractic care? □ Yes □ No
    Was it for this problem? If so, where? When? _____
13. Have you tried a home exercise program to treat this? If yes, for how long? _____
14. Have you had any recent injections? □ Yes □ No
    If so, when? By which doctor? _____

Please mark the figure with the location of your symptoms.

Mark pain areas as "XX"

Mark numbness/tingling as "OO"



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Medication Log

Name: _____ D.O.B.: _____ Date: _____

Pharmacy: _____ Pharmacy phone #: _____

Known Drug Allergies: _____

Medications patient is currently on:

Date	Medication Name	Strength	Qty	Freq	Reason	Prescribing Doctor

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Name: _____ D.O.B.: _____ Date: _____

Please mark the following which apply to you:

Tobacco use/type: _____ Coffee/cups per day: _____

Alcohol: _____ Highest grade level completed: _____

Illicit drugs: _____

Have you ever been dismissed from another Medical Practice? □ Yes □ No

If yes, why? _____

Briefly, please describe your job/work duties: _____

Have you previously had any spinal or orthopedic surgeries? □ Yes □ No If yes, when? _____

What type of surgery? _____

Please check "**Yes**" or "**No**" to the following conditions you currently or have suffered from in the past:

	Yes	No		Yes	No		Yes	No
Heart disease:	□	□	Arthritis:	□	□	Fibromyalgia:	□	□
Heart attack:	□	□	Diabetes:	□	□	Prior back injuries:	□	□
Stroke:	□	□	Stomach ulcers:	□	□	Drug/alcohol dependence:	□	□
Asthma:	□	□	Kidney Stones:	□	□			
COPD/Emphysema:	□	□	Thyroid problems:	□	□	Cancer: If so, type: _____	□	□

Other:

_____

_____

Please mark the box with an "**X**" which conditions apply to a relative.

Condition:	Mom	Dad	Sibling 1	Sibling 2	Sibling 3	Children	Other close relatives
Heart disease							
Diabetes							
Cancer							
Rheumatologic conditions							
Psychiatric problems							
High blood pressure							
Stroke							

Other: _____

_____

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Name:_____ D.O.B.: _____ Date: _____

Please check "**Yes**" or "**No**" to the following conditions you currently or have suffered from in the past:

Musculoskeletal:	**Yes**	**No**
Neck pain:	□	□
Shoulder pain:	□	□
Upper arm pain:	□	□
Elbow pain:	□	□
Jaw pain:	□	□
Hand pain:	□	□
Upper back pain:	□	□
Low back pain:	□	□
Upper leg or hip pain:	□	□
Lower leg or knee pain:	□	□
Ankle or foot pain:	□	□
Joint swelling:	□	□
Joint stiffness:	□	□

Neurological/Psychiatric:		
Memory loss:	□	□
Depression:	□	□
Insomnia:	□	□
Headaches:	□	□
In-coordination:	□	□
Fainting:	□	□
Convulsions:	□	□
Dizziness:	□	□
Loss of balance:	□	□

Cardiovascular:		
Rapid heartbeat:	□	□
Irregular heart beats:	□	□
Chest pain:	□	□

Constitutional:		
Fever:	□	□
Hair loss:	□	□
Chills:	□	□
Loss of appetite:	□	□
Weight gain/loss:	□	□

Respiratory:	**Yes**	**No**
Shortness of breath:	□	□
Chronic cough:	□	□
Chronic sinusitis:	□	□

Gynecological:		
Pain during menstruation:	□	□
Irregular menstrual flow:	□	□
Menopausal symptoms:	□	□

Genitourinary:		
Painful urination:	□	□
Urethral discharge:	□	□
Loss of bladder control:	□	□

Gastrointestinal:		
Abdominal pain:	□	□
Constipation:	□	□
Difficulty swallowing:	□	□
Heartburn/indigestion:	□	□

Skin:		
Rashes:	□	□
Persistent itching:	□	□
Dermatitis or eczema:	□	□

Eyes & Ears:		
Vision loss:	□	□
Eye pain:	□	□
Dry eyes:	□	□
Tinnitus (ear noise):	□	□
Hearing loss:	□	□
Ear pain:	□	□

Review of systems completed with patient by Physician on: _____

Updated on: _____

_____ _____
Sign Date

_____ _____
Sign Date

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers
3. Conduct normal healthcare operations such as quality assessments and Physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization as the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Print Patient Name:_____

Signature:_____

Relation to Patient (if other than self):_____ Date:_____

Please check this area if you do not wish to receive voice messages from us: _____

This form authorizes employees of PM&R North, Inc. to discuss my medical condition with the people I have listed below. There will be no restrictions, including no end date, on the information that may be disclosed. This release may only be revoked in writing by the patient or their personal representative.

Print Name	Relationship

☐ By checking this box, I understand that I **do not** want my medical condition to be discussed with anyone other than myself.

Witness Name:_____ Date:_____

Witness Signature:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so, as documented below.

Date:	Initials:	Reason: