

CORAL SPRINGS

PHYSICAL MEDICINE

Health Questionnaire

Name: _____ Age _____ Home Phone #: _____ Work Phone #: _____

Address: _____ City: _____ State _____ Zip: _____

Occupation: _____ # Hours/Week Currently Working: _____

E-mail Address: _____ Cell Phone #: _____

Check off any of the following symptoms you have experienced in the past 6 months:

- | | | |
|---|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Tension Across Top of Shoulders | <input type="checkbox"/> Tired/Fatigued |
| <input type="checkbox"/> Pain between Shoulder Blades | <input type="checkbox"/> Numbness/Tingling in Arms/Hands | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness/Tingling in Legs/Feet | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Tension/Headaches | <input type="checkbox"/> Pain in the legs | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pain in the feet | <input type="checkbox"/> Carpal Tunnel |

OTHER (explain) _____

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like?(describe) _____

What have you done that has helped this problem? _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:

- Moody
- Irritable
- Interrupt sleep
- Restricted in your daily activities

Does this affect your work:

- Decision making
- Poor attitude
- Decreased productivity
- Exhausted at the end of the day
- Unable to work long hours

Does this affect your life:

- Lose patience with spouse/children
- Restricted household duties
- Hinders ability to exercise or sports
- Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

- | | |
|---|---|
| ◆ Medications...Helped: Little Some Much | ◆ Exercise...Helped: Little Some Much |
| ◆ Physical Therapy...Helped: Little Some Much | ◆ Nutrition...Helped: Little Some Much |
| ◆ Chiropractic...Helped: Little Some Much | ◆ Stretching...Helped: Little Some Much |

OTHER _____

Location

Date:

Apt:

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: _____ Date: ____/____/____

How did you hear about us?

W E L C O M E

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____
City State Zip

Phone # (H) _____ (W) _____ (Other) _____

Can we call you at work? Yes No

Date of Birth: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Race Caucasian African American Asian Native American Latin American Other _____

Ethnicity Hispanic Latino Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other _____

Has it been reported? Yes No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. : _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ DATE _____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/ removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X _____ I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of _____.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X _____
Signature of Patient/Guardian

Date

Witness (Office Staff)

Date

Patient Signature

Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient's Signature

Date

PATIENT

Review of Systems

Name _____

Date _____

Y	N	
		Neurological
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	
		Skin
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ DATE _____

For any YES answer, please include details.

- | | | |
|--|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do our legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Do have frequent falls or find that you trip over your feet while walking?
Comment: _____ | NO | YES |
| 12. Do you suffer from headaches? If yes, how often, how severe, what has been tried?
Comment: _____ | NO | YES |
| 13. Have you tried any medications such as anti-inflammatory?
If yes, what kind of medication? | NO | YES |
| 14. Have you tried any Physical Therapy or Chiropractic treatments before?
If yes: When? For how long? What kind? | NO | YES |
| 15. Have you had an MRI?
If yes: When? Who ordered it? What was it ordered for? | NO | YES |
| 16. Have you used any splint or braces or other prescribed treatment by an MD?
If yes: When? What kind? Who ordered it? | NO | YES |
| 17. If you have tried any treatment or medications, did this make your problem better?
Comment: _____ | NO | YES |