SPECIALISTS IN REHABILITATION MEDICINE, P.C.

WELCOME TO OUR OFFICE!

DATE: _____

PATIENT INFORMATION

LAST NAME, FIRST NAME, MIDDLE INITIAL:			
ADDRESS:			
CITY, STATE, ZIP:			
HOME PHONE: ( )		MOBILE PHONE: ( )	
WORK PHONE: ( )		GENDER: ☐ M ☐ F	LANGUAGE:
DATE OF BIRTH:	AGE:	SOC SEC NUMBER:	
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ PARTNER			
RACE: ☐ BLACK/AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ AMERICAN INDIAN/NATIVE ALASKAN ☐ OTHER _____			
ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC		OCCUPATION:	
EMAIL ADDRESS:			
CONFIRM MY APPOINTMENT VIA: ☐ EMAIL ☐ TEXT		REFERRING DOCTOR:	

PHARMACY INFORMATION

PHARMACY:	CITY:
CROSS STREETS:	PHONE NUMBER: ( )

INSURANCE INFORMATION

IS THIS VISIT RELATED TO: ☐ WORK INJURY ☐ AUTO ACCIDENT ☐ N/A (SKIP TO NEXT SECTION)		
DATE OF INJURY:	LOCATION OF INJURY: (i.e. BACK, KNEE, ARM)	
CLAIM NUMBER:		INSURANCE COMPANY NAME:
ADJUSTER'S NAME:		PHONE NUMBER: ( )
BILLING ADDRESS:		

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY NAME:		
SUBSCRIBER'S NAME:		
SUBSCRIBER'S SOC SEC NUMBER:		
SUBSCRIBER'S DATE OF BIRTH:		

IN CASE OF EMERGENCY – WHOM SHOULD WE CONTACT?

NAME: _____ PHONE #: _____

RELATIONSHIP: _____

Do you want Medical Health Record or Billing Information shared with this person? ☐ Yes ☐ No

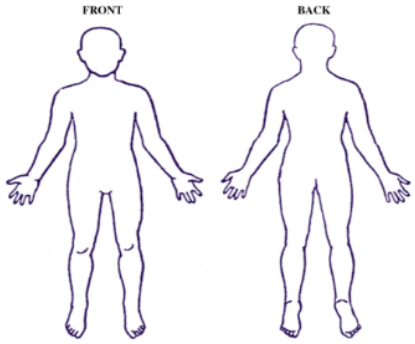
Name: _____
Age: _____

HANDEDNESS: ☐ RIGHT HANDED ☐ LEFT HANDED ☐ AMBIDEXTROUS

	REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN
NAME:		
PHONE NUMBER:		

EMPLOYER:
OCCUPATION:
JOB RESPONSIBILITIES:
LAST DAY WORKED:

REASON FOR TODAY'S VISIT:



PLEASE MARK YOUR AREA OF PAIN

PROBLEMS FOR WHICH YOU ARE HERE:
(i.e. BACK/NECK/LEGS/ETC)

1. _____
2. _____
3. _____

WHEN DID YOUR PROBLEM START? _____

HOW DID IT START? _____

NAME ALL TREATMENTS (i.e. HEAT, ICE, REST, ETC.) _____

_____

ARE YOU GETTING BETTER, WORSE, OR STAYING THE SAME? _____

HOW WOULD YOU RATE YOUR PAIN NOW?
(CIRCLE THE NUMBER YOU WOULD GIVE IT, IF "**1**" IS NO PAIN AND "**10**" IS THE WORST PAIN EVER)

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

HOW WOULD YOU RATE YOUR PAIN AT ITS WORST?
(CIRCLE THE NUMBER YOU WOULD GIVE IT, IF "**1**" IS NO PAIN AND "**10**" IS THE WORST PAIN EVER)

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

FEMALE ONLY:

ARE YOU PREGNANT? ☐ YES ☐ NO ☐ N/A

ARE YOU CURRENTLY BREASTFEEDING? ☐ YES ☐ NO ☐ N/A

ARE YOU CURRENT WITH YOUR PELVIC EXAM/PAP SMEAR? ☐ YES ☐ NO ☐ N/A

ARE YOU CURRENT WITH YOUR MAMMOGRAM? ☐ YES ☐ NO ☐ N/A

NAME ALL MEDICAL HISTORY (STROKE, CANCER, ETC.)

1. _____
2. _____
3. _____
4. _____

NAME ALL SURGERIES AND DATES

1. _____
2. _____
3. _____
4. _____

NAME ALL MEDICATIONS YOU ARE TAKING (INCLUDING OVER THE COUNTER MEDICATIONS) _____

_____

_____

_____

MEDICATION ALLERGIES _____

_____

DO YOU SMOKE? ☐ **YES** ☐ **NO** IF YES, HOW MANY PACK'S PER DAY?_____

HAVE YOU SMOKED IN THE PAST? ☐ **YES** ☐ **NO** IF YES, HOW LONG AGO DID YOU QUIT?_____

DO YOU CONSUME ALCOHOL? ☐ **YES** ☐ **NO** HOW OFTEN? _____

DO YOU USE ILLICIT DRUGS? ☐ **YES** ☐ **NO**

_____

PERTINENT FAMILY MEDICAL HISTORY (PARENTS, BROTHERS, SISTERS, & CHILDREN) _____

_____

_____

ARE YOU CURRENTLY, OR HAVE YOU HAD A PROBLEM WITH? (CIRCLE YES OR NO)

CONSTITUTIONAL

FEVER / CHILLS	YES	NO	IF YES, EXPLAIN	_____
WEIGHT LOSS / GAIN	YES	NO	IF YES, EXPLAIN	_____
FATIGUE	YES	NO	IF YES, EXPLAIN	_____
NIGHT SWEATS	YES	NO	IF YES, EXPLAIN	_____

EYES

INFECTIONS	YES	NO	IF YES, EXPLAIN	_____
DOUBLE VISION	YES	NO	IF YES, EXPLAIN	_____
BLURRED VISION	YES	NO	IF YES, EXPLAIN	_____

EAR, NOSE & THROAT

HEARING LOSS	YES	NO	IF YES, EXPLAIN	_____
EAR PAIN	YES	NO	IF YES, EXPLAIN	_____
RINGING IN EARS	YES	NO	IF YES, EXPLAIN	_____
LOSS OF BALANCE	YES	NO	IF YES, EXPLAIN	_____
NASAL DRAINAGE	YES	NO	IF YES, EXPLAIN	_____
LOSS OF SMELL	YES	NO	IF YES, EXPLAIN	_____
SORE THROAT	YES	NO	IF YES, EXPLAIN	_____

CARDIOVASCULAR

CHEST PAIN	YES	NO	IF YES, EXPLAIN_____
IRREGULAR PULSE	YES	NO	IF YES, EXPLAIN_____
HEART MURMUR	YES	NO	IF YES, EXPLAIN_____
SWELLING OF FEET	YES	NO	IF YES, EXPLAIN_____

RESPIRATORY

COUGH	YES	NO	IF YES, EXPLAIN_____
SHORTNESS OF BREATH	YES	NO	IF YES, EXPLAIN_____
WHEEZING	YES	NO	IF YES, EXPLAIN_____

ENDOCRINE/GENITOURINARY

INCREASED THIRST	YES	NO	IF YES, EXPLAIN_____
INCREASED URINATION	YES	NO	IF YES, EXPLAIN_____
URINARY INCONTINENCE	YES	NO	IF YES, EXPLAIN_____
HOT / COLD	YES	NO	IF YES, EXPLAIN_____
BURNING OF URINE	YES	NO	IF YES, EXPLAIN_____

GASTROINTESTINAL

NAUSEA AND VOMITING	YES	NO	IF YES, EXPLAIN_____
JANUDICE	YES	NO	IF YES, EXPLAIN_____
DIARRHEA	YES	NO	IF YES, EXPLAIN_____
CONSTIPATION	YES	NO	IF YES, EXPLAIN_____

MUSCULO-SKELETAL

NECK PAIN	YES	NO	IF YES, EXPLAIN_____
BACK PAIN	YES	NO	IF YES, EXPLAIN_____
ARM WEAKNESS	YES	NO	IF YES, EXPLAIN_____
LEG WEAKNESS	YES	NO	IF YES, EXPLAIN_____
JOINT PAIN	YES	NO	IF YES, EXPLAIN_____
ARTHRITIS	YES	NO	IF YES, EXPLAIN_____
ARM / LEG NUMBNESS	YES	NO	IF YES, EXPLAIN_____

NEUROLOGICAL

LOSS OF MEMORY	YES	NO	IF YES, EXPLAIN_____
DISORIENTATION	YES	NO	IF YES, EXPLAIN_____
SPEECH DIFFICULTY	YES	NO	IF YES, EXPLAIN_____
FACIAL WEAKNESS	YES	NO	IF YES, EXPLAIN_____
SEIZURES	YES	NO	IF YES, EXPLAIN_____
HEADACHES	YES	NO	IF YES, EXPLAIN_____

HEMATOLOGIC

BLEEDING TENDENCIES	YES	NO	IF YES, EXPLAIN_____
ANEMIA	YES	NO	IF YES, EXPLAIN_____
SWOLLEN GLANDS	YES	NO	IF YES, EXPLAIN_____

OTHER

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE: _____ DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____