Chart #____________
OFFICE USE ONLY

PATIENT INFORMATION AND INSURANCE FORM – PG 1/2

5333 McAuley Drive
Suite 2009
Ypsilanti MI, 48197

www.APMandR.com

734.712.0050 p
734.712.0055 f

Today's Date ___ / ___ / ___

Name ____________________

Address ____________________

____________________ Apt# ____________

City ____________________ State __________ Zip __________

Home Phone (__ __ __) __ __ __ – __ __ __ __ Work Phone (__ __ __) __ __ __ – __ __ __ __

Cell Phone (__ __ __) __ __ __ – __ __ __ __ E-Mail ____________________

Patient Date of Birth ___ / ___ / ___ Social Security # __ __ __ – __ __ – __ __ __ __

Race:

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Two or More Races
☐ Refused to Report

Ethnicity:

☐ Hispanic ☐ Non-Hispanic or Latino
☐ Refused to Report

Preferred Language:

☐ English ☐ Spanish ☐ Indian ☐ Arabic ☐ Other ☐ Refuse to Report

Additional Contact Information

Phone Messages – Please check preferred number for our office to leave messages:

☐ Home ☐ Work ☐ Cell

Please check box with type of information that is acceptable to leave on phone message:

☐ Message of call only ☐ Test results ☐ Any other medical information

Do we have permission to speak to an immediate family member about your condition?

☐ Yes ☐ No

Emergency Contact Name ____________________

Emergency Contact Phone (__ __ __) __ __ __ – __ __ __ __

Referral Information

Who referred you to our office?

Name ____________________

– – please provide insurance information on next page – –

Chart #__________________
OFFICE USE ONLY

PATIENT INFORMATION AND INSURANCE FORM – PG 2/2

Is this Worker's Compensation? ☐ Yes ☐ No

Is this related to an Automobile Accident? ☐ Yes ☐ No

If you answered yes to either of the above, please fill out information below. If you answered no, please fill out primary insurance coverage.

Date of Injury____ / ____ / ____ Claim # ______________________________

Adjustor Name ____

Primary Insurance Coverage

Name of Insurance ____

Company Address ____

Company Phone # (__ __ __) __ __ __ – __ __ __ __

Subscriber's Name ____

Subscriber's Date of Birth ____ / ____ / ____ Subscriber's Relationship to Patient ______________

Subscriber's Employer____

Employer's Address____

Phone # (__ __ __) __ __ __ – __ __ __ __

Contract # __________________________ Group # ____________________

Secondary Insurance Coverage

Name of Insurance ____

Company Address ____

Company Phone # (__ __ __) __ __ __ – __ __ __ __

Subscriber's Name ____

Subscriber's Date of Birth ____ / ____ / ____ Subscriber's Relationship to Patient ______________

Subscriber's Employer____

Employer's Address____

Phone # (__ __ __) __ __ __ – __ __ __ __

Contract # __________________________ Group # ____________________

Who will be responsible for your balance after insurance pays?

Name ____

Address______________________________ Apt #__________________

City ______________________________ State__________ Zip__________

Phone (__ __ __) __ __ __ – __ __ __ __

<u>AUTHORIZATION FOR DIRECT INSURANCE PAYMENT</u>: I hereby authorize direct payment to Associates in Physical Medicine & Rehabilitation by the insurance carrier for services rendered to me. Regardless of whether or not direct payment is authorized, I understand that I am still financially responsible for any charges incurred until such time the account is settled.

Signed ______________________________ Date ____________________

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BRAIN • PAIN • SPORTS • SPINE

Name: ______________________ **DOB:** ___ / ___ / ___ **Today's Date:** ___ / ___ / ___

PATIENT HISTORY FORM – INITIAL VISIT PG 1/3

Referral Information:

(Who Referred You)
Name: ______________________
Address: ______________________
City, State, Zip: ______________________

(Primary Doctor/Internist)
Name: ______________________
Address: ______________________
City, State, Zip: ______________________

Current Employment:

Name: ______________________
Address: ______________________
Occupation: ______________________
City, State, Zip: ______________________

Presenting Problem:
(Check all that apply)

- ☐ Pain
- ☐ Sensory Loss
- ☐ Weakness
- ☐ Limited Motion
- ☐ Cognitive Problems
- ☐ Memory Loss
- ☐ Speech Disorder
- ☐ Swallowing Disorder
- ☐ Balance Problems
- ☐ Clumsiness / Falls
- ☐ Walking Difficulty
- ☐ Bladder Difficulty
- ☐ Problem Climbing Steps
- ☐ Impaired Hand Coordination
- ☐ Spasms / Spasticity
- ☐ Skin Breakdown
- ☐ Impairment in Ability to Work
- ☐ Inability to Care for Self
- ☐ Difficulty With Communication
- ☐ Change in Medical Condition

Description of why you are seeing the doctor *(use back of pg 3 for additional space)*: ______________________

____

____

____

____

____

____

Severity of Pain, if applicable: *(Circle the area on the line which best describes your current level of pain)*

No Pain — Moderate Pain — Worst Possible Pain

What makes your pain worse?

- ☐ Lying Down
- ☐ Sitting Down
- ☐ Standing
- ☐ Walking
- ☐ During Exercise
- ☐ After Exercise
- ☐ Bending
- ☐ Lifting
- ☐ Coughing
- ☐ Sneezing
- ☐ Bowel Movement
- ☐ Reaching
- ☐ Twisting
- ☐ Pull/Push
- ☐ Work Activities
- ☐ Riding in Car
- ☐ Other______________________

What makes your pain better?

- ☐ Lying Down
- ☐ Sitting Down
- ☐ Standing
- ☐ Walking
- ☐ Manipulation
- ☐ Massage
- ☐ Prescription Pain Pill
- ☐ Muscle Relaxing
- ☐ Coughing
- ☐ Sneezing
- ☐ Bowel Movement
- ☐ Reaching
- ☐ Twisting
- ☐ Pull/Push
- ☐ Work Activities
- ☐ Riding in Car
- ☐ Other______________________

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Name: ______________________ **DOB:** __ / __ / __ **Today's Date:** __ / __ / __

PATIENT HISTORY FORM – INITIAL VISIT PG 2/3

Past Medical History:

____
____
____
____

Medication Allergies:

____
____
____
____

Currently Working?

- ☐ No, last day worked: __________
- ☐ Yes, without restrictions
- ☐ Yes, restrictions: __________

Past Surgical History:

____
____
____
____
____
____

Check any that apply:

- ☐ Injury on the Job *(date)* __________
- ☐ Auto Accident *(date)* __________
- ☐ Working with Rehab Nurse
- ☐ Receiving Workers Comp.
- ☐ Receiving Disability Income
- ☐ Legal Proceedings Pending *(Attny Name:__________)*

Family History:

A= Alive / D= Deceased / Age — Example

Mother [/] 1
Father [/] 2
Brothers [/] 3 [/] 4 [/] 5 [/] 6
Sisters [/] 7 [/] 8 [/] 9 [/] 10

Family Medical History: *(If applies, indicate which member using numbers above – modify as necessary)*

___	Heart Disease	___	Hypertension
___	Cancer	___	Alzheimers
___	Stroke	___	Arthritis
___	Diabetes	___	Osteoporosis

Medications: *(Rx and Non-Rx)*

____
____
____
____
____

Do You: *(If Yes, indicate what you use and the amount per day)*

- ☐ Smoke? __________
- ☐ Use Alcohol? __________
- ☐ Use Non-Rx Drugs? __________

____

Review of Systems *(circle all that apply, then expand on below)*

Constitutional

Fevers	Y	N
Chills	Y	N
Weight Loss	Y	N
Night Sweats	Y	N
Travel Out of Country	Y	N
Skin Rashes or Lesions	Y	N

Neurologic

Tremors	Y	N
Dizziness	Y	N
Seizures	Y	N
Sensory Loss	Y	N
Weakness	Y	N
Loss of Balance	Y	N

Cardiovascular

Chest Pain	Y	N
Rapid Heartbeat	Y	N
High Blood Pressure	Y	N
Fainting Spells	Y	N
Irregular Hearbeat	Y	N
Swelling in Ankles/Feet	Y	N

Endocrine

Fatigue/Wt. Gain	Y	N
Thermal Intolerance	Y	N
Excessive Thirst	Y	N
Goiter	Y	N
Fluid Retention	Y	N

Musculoskeletal

Joint Pain	Y	N
Swollen Joint(s)	Y	N
Neck or Back Pain	Y	N
Weakness	Y	N
Limited Movement	Y	N

Special Senses

Blurred Vision	Y	N
Double Vision	Y	N
Loss of Vision	Y	N
Loss of Taste/Smell	Y	N
Loss of Hearing	Y	N

Gastrointestinal

Abdominal Pain	Y	N
Heartburn	Y	N
Difficulty Swallowing	Y	N
Blood in Stools	Y	N
Black/Tarry Stools	Y	N
Incontinence	Y	N

Respiratory

Wheezing	Y	N
Shortness of Breath	Y	N
Chronic Cough	Y	N
Coughing Blood	Y	N
Frequent URI	Y	N

OB/Gynec

Date of LMP __________
Date of Last Pap __________
Last Mammogram __________
# of Pregnancies __________
# of Living Children __________

Excessive Bleeding	Y	N
Breast Mass/Discharge	Y	N

Genitourinary

Urinary Retention	Y	N
Urinary Frequency	Y	N
Decreased Stream	Y	N
Blood in Urine	Y	N
Incontinence	Y	N
Testicular Pain/Mass	Y	N
Erectile Dysfunction	Y	N

Ears/Nose/Throat

Ear Pain	Y	N
Ringing in Ears	Y	N
Sore Throat	Y	N
Sores in Mouth	Y	N
Sinus Congestion	Y	N
Sinus Drainage	Y	N

Hemat./Lymphatic

Swollen Glands	Y	N
Tender Glands	Y	N
Blood Transfusion	Y	N
Excessive Bruising	Y	N
Spontaneous Bleeding	Y	N
Edema	Y	N

Psychiatric

Depression	Y	N
Anxiety	Y	N
Flight of Ideas	Y	N
Thoughts of Suicide	Y	N
Interrupted Sleep	Y	N

The information obtained through this section of these forms provides vital information that allows our doctors to consider all the information about your condition to facilitate optimal care. Please take your time and fill these in as completely as possible. Circle any item if you need clarification about it at the time of your visit.

____
____
____

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Name: ______________________ **DOB:** ___ / ___ / ___ **Today's Date:** ___ / ___ / ___

PATIENT HISTORY FORM – INITIAL VISIT PG 3/3

Pain Diagram:
Mark these drawings according to where you feel your symptoms are located. Please use the following Diagram Key to indicate what you are feeling or have felt. If the markings don't apply to what you feel, then try to use your own words to describe what it is that you feel.

Diagram Key

Numbness
= = = = =

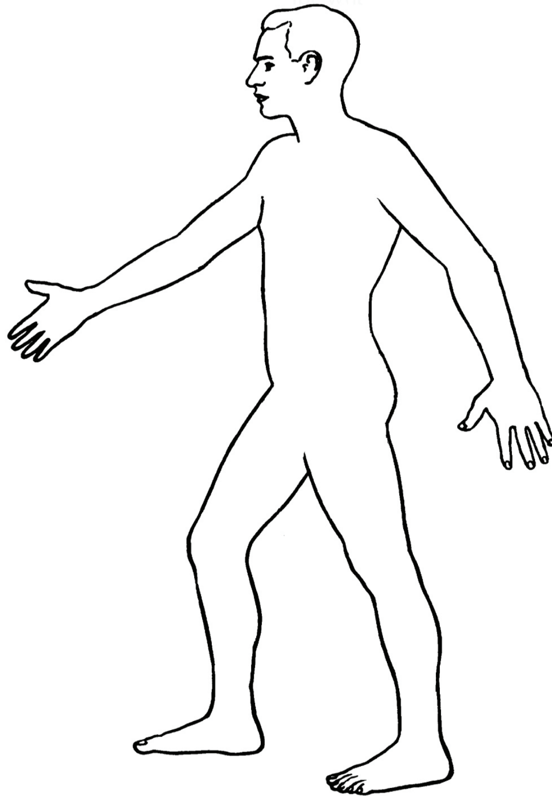
Pins and Needles
0 0 0 0 0

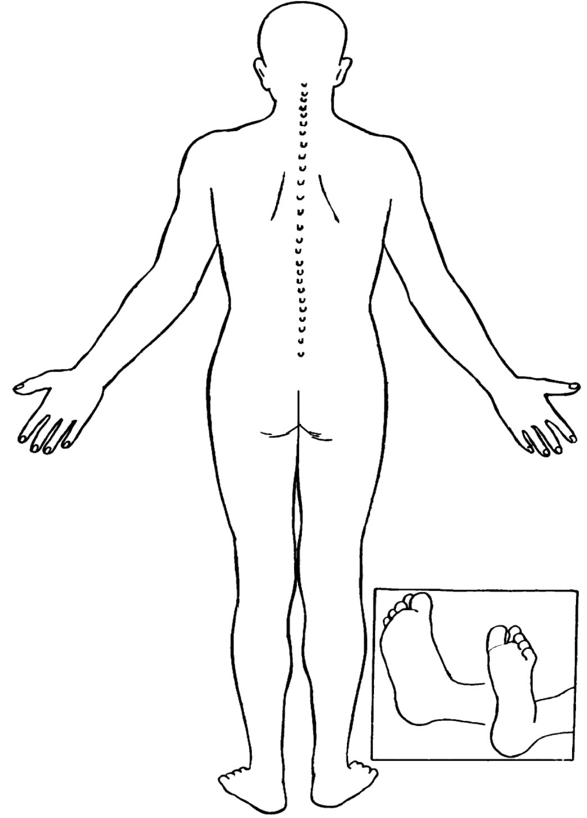
Burning
X X X X X

Stabbing
/ / / / /

Aching
* * * * * *

Throbbing
+ + + + + +





Previous Tests: *(Check any that apply)*

✔	Date	Where Done
☐ Plain X-rays		
☐ CT Scan		
☐ MRI		
☐ Myelogram		
☐ Discogram		
☐ EMG/NCS		

Describe Results: ______________________

____

____

____

____

Previous Treatments: *(Check any that apply)*

✔	Date	Where Done
☐ Physical Therapy		
☐ Chiropractic		
☐ Acupuncture		
☐ Bracing/Orthotic		
☐ Pain Clinic/Epidural		
☐ Surgery		
☐ Rest		
☐ Medications		

Describe Results: ______________________

____

____

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LIMITED PATIENT AUTHORIZATION FORM – PG 1/2

FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO AN INDIVIDUAL.

Please print all information. Form must be signed and dated each year, see page 2.

Patient Name ______________________________ Chart # __________

Date of Birth ___ / ___ / ___ Social Security # _ _ _ – _ _ – _ _ _ _

Who will provide or disclose information?

Practice Name Associates in Physical Medicine and Rehabilitation

Provider ______________________________

Address 5333 McAuley Drive, Suite 2009

City Ypsilanti State MI Zip 48197

Phone (7 3 4) 7 1 2 – 0 0 5 0

Who will be authorized to receive information?

(List each family member, friend or other individual to receive PHI)

Name ______________________________

Relationship ______________________ Phone (_ _ _) _ _ _ – _ _ _ _

Name ______________________________

Relationship ______________________ Phone (_ _ _) _ _ _ – _ _ _ _

Name ______________________________

Relationship ______________________ Phone (_ _ _) _ _ _ – _ _ _ _

Name ______________________________

Relationship ______________________ Phone (_ _ _) _ _ _ – _ _ _ _

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire Patient Record; **or check only** those items of the record to be disclosed:

- ☐ Office notes ☐ Lab results ☐ X-rays ☐ Prescriptions
- ☐ Nursing home, home health, hospice, and other physician records
- ☐ Record of HIV and communicable disease testing
- ☐ Record of mental health or substance abuse treatment
- ☐ Financial history report (previous 3 years only)

☐ Only send the following ______________________________

____

LIMITED PATIENT AUTHORIZATION FORM – PG 2/2

Do we have permission to speak to an immediate family member about your condition?

☐ Yes ☐ No

Purpose of disclosure
(please record the purpose of the disclosure or check patient request)

☐ Patient Request

☐ Other (please specify) ____

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

Please list date of expiration if earlier than end of calendar year ____________________

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature ____________________________________ Date ____ / ____ / ____

Patient Signature ____________________________________ Date ____ / ____ / ____

Patient Signature ____________________________________ Date ____ / ____ / ____

Patient Signature ____________________________________ Date ____ / ____ / ____

Patient Signature ____________________________________ Date ____ / ____ / ____

Patient Signature ____________________________________ Date ____ / ____ / ____

You have the right to receive a copy of signed authorizations upon request.