APM&R
BRAIN • PAIN • SPORTS • SPINE

5333 McAuley Drive
Suite 2009
Ypsilanti MI, 48197

www.APMandR.com

**p**. 734.712.0050
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# PATIENT INFORMATION AND INSURANCE FORM – PG 1/2

**Today's Date** ___ / ___ / ___

Name _____

Address _____

_____ Apt# _____

City _____ State _____ Zip _____

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

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

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

Do you have a guardian or personal representative? ☐ No ☐ Yes *(fill out below)*

Name _____

Address _____ Apt # _____

City _____ State _____ Zip _____

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

## 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 (__ __ __) __ __ __ – __ __ __ __

## Employer Information

Patient Employer _____

Employer Address _____

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

## Referral Information

Who referred you to our office?

Name _____

*– – please provide insurance information on next page – –*

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## 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 _____

Case Manager/Rehab Nurse _____

Insurance Company Name _____

Company Address _____

City _____ State_____ Zip _____

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

**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 # _____

**AUTHORIZATION FOR DIRECT INSURANCE PAYMENT**: 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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**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: _____ Occupation: _____

Address: _____ 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:

_____
_____
_____
_____

### Past Surgical History:

_____
_____
_____
_____
_____
_____

### Medications: *(Rx and Non-Rx)*

_____
_____
_____
_____
_____

### Medication Allergies:

_____
_____
_____
_____

### 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:_____)*

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

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

_____

### Currently Working?

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

### 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 |

---

### 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
= = = = =

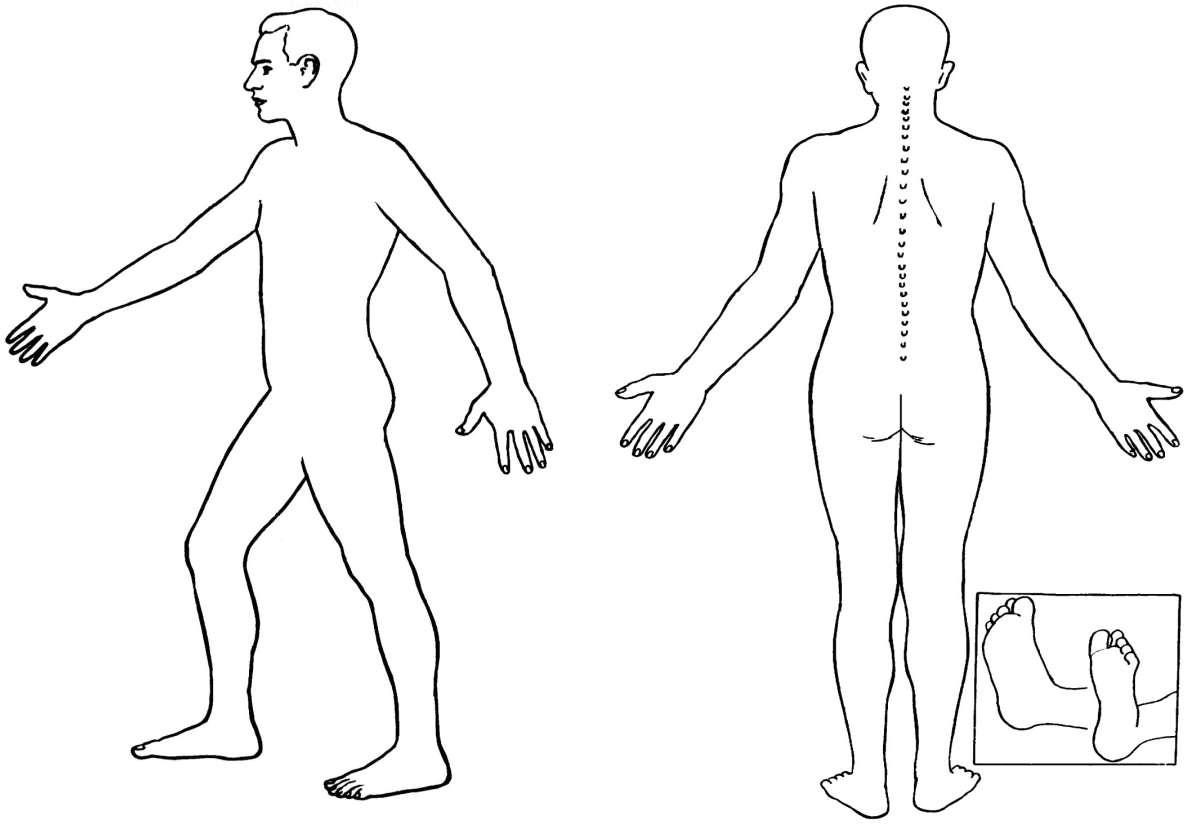
Pins and Needles
0 0 0 0 0

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 _____

_____

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## 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.*