WELCOME

AdvantageHealth & Rehabilitation Centers

PATIENT INFORMATION

Date ____________________

Social Security # ____________________

Patient Name ____________________
Last Name

____
First Name Middle Initial

Address ____________________

City ____________________

State ____________________ Zip __________

E-mail ____________________

Sex ☐M ☐F Age__________

D.O.B. ____________________

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered for ______ years

Occupation ____________________

Patient Employer ____________________

Employer address ____________________

____

Employer Phone (_____) ____________________

Spouse's Name ____________________

D.O.B. ____________________

Social Security # ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________________

____

PHONE NUMBERS

Home Phone (_____) ____________________

Cell Phone (_____) ____________________

May we text you? ☐Yes ☐No

IN CASE OF EMERGENCY, CONTACT:

Name ____________________

Relationship ____________________

Home Phone (_____) ____________________

Work Phone (_____) ____________________

May we discuss your medical condition with this person? ☐Yes ☐No

INSURANCE

Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

ID # ____________________

Group # ____________________

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name ____________________

Birthdate ____________________ SS# ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

ID # ____________________

Group # ____________________

PATIENT CONDITION

WHAT IS THE REASON FOR YOUR VISIT?

Major complaint ____________________

____

____

____

Please describe your symptoms ____________________

____

____

____

How and when did your symptoms begin? ____________________

____

____

What gives you relief? ____________________

____

What makes it worse? ____________________

____

Associated symptoms (pain, weakness, numbness, bowel or bladder problems, headaches, etc.) ____________________

____

____

____

____

Please list any past treatments you have received for your current problem (including any medications, injections, physical therapy, chiropractic care, surgery, etc.):

____

____

Pharmacy name and phone number:

____

Office location (please circle): **MG** **MV** **WV** **CV** **GV**

FAMILY HISTORY: PLEASE PROVIDE INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

	Alive or Deceased	*Age*	*Health Status or Cause of Death*
Mother			
Father			
Sister / Brother			
Sister / Brother			
Sister / Brother			
Sister / Brother			

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	RADIATING PAIN
^ ^ ^	O O O	■ ■ ■	X X X	///
^ ^ ^	O O O	■ ■ ■	X X X	///
^ ^ ^	O O O	■ ■ ■	X X X	///

Neck Pain ________ %

Arm Pain ________ %

Back Pain ________ %

Leg Pain ________ %

Total = 100%

RIGHT LEFT LEFT RIGHT

PLEASE MARK ON THE LINE:

How bad is your pain now?

❶_______❷_______❸_______❹_______❺_______❻_______❼_______❽_______❾_______❿

NO PAIN **INTERMEDIATE PAIN** **WORST PAIN**

PLEASE PROVIDE A LIST OF YOUR CURRENT MEDICATIONS AND VITAMINS / HERBAL SUPPLEMENTS:

Name	*Dose*	*Frequency*

Do you currently take *aspirin* or *products containing aspirin*? ☐Yes ☐No

If yes, what is the brand name? ______________________________

Are you taking any blood thinning medications, such as *Coumadin, Plavix,* or *Lovenox*? ☐Yes ☐No

If yes, what is the name of the medication? ______________________________

Do you have any *allergies to medications or food*? ☐Yes ☐No

If yes, please list and include reaction: ______________________________

Which hand do you write with? (Please check one): Right ___ Left ___ Ambidextrous (both) ___

Are you claustrophobic? ☐Yes ☐No Can you have a closed MRI scan? ☐Yes ☐No

Have you ever had any of the following procedures? (If yes, provide date)

CT scan	☐Head ______	☐Neck _____	☐Back _____	Date ____________
MRI	☐Head ______	☐Neck _____	☐Back _____	Date ____________
Myelogram		☐Neck _____	☐Back _____	Date ____________
Plain x-rays		☐Neck _____	☐Back _____	Date ____________

☐EMG ____________ ☐Stress Test ____________ ☐Angiogram ____________ ☐Angioplasty ____________ ☐Catheterization ____________

☐Open Heart Surgery ____________ ☐Carotid / Coronary Artery Stenting ____________ ☐Nerve Conduction Study ____________

Are you currently being treated for any medical conditions (i.e.: diabetes, hypertension)? ☐Yes ☐No

If yes, please explain: ______________________________

Have you ever been diagnosed with any type of cancer? ☐Yes ☐No

If yes, please list the type and approximate date of diagnosis: ______________________________

Do you have sleep apnea? ☐Yes ☐No If yes, do you use a CPAP machine? ☐Yes ☐No

PLEASE LIST ANY PREVIOUS SURGERIES OR HOSPITALIZATIONS:

Surgery / Hospitalization	*Approximate Date*	*Treating Doctor*

If female, are you currently pregnant? ☐Yes ☐No

REVIEW OF SYSTEMS – Are you currently, or have you in the past 3 years, had problems with any of the following:

Fever .... YES NO
Weight loss .... YES NO
Excessive fatique .... YES NO
Night sweats .... YES NO
Eye injuries .... YES NO
Wear glasses .... YES NO
If yes, date of last exam________________
Double or blurred vision .... YES NO
Wear a hearing aid .... YES NO
If yes, date of last exam________________
Hearing loss .... YES NO
Balance disturbance .... YES NO
(vertigo/spinning)
Inability to smell .... YES NO
Chest pain or angina .... YES NO
If yes, date of last EKG________________
High blood pressure .... YES NO
Irregular pulse .... YES NO
Heart murmur .... YES NO
Congestive heart failure .... YES NO
High cholesterol .... YES NO
Swelling in feet or hands .... YES NO
Leg pain while walking .... YES NO
Asthma .... YES NO
Chronic cough .... YES NO

Emphysema .... YES NO
Shortness of breath .... YES NO
Tuberculosis .... YES NO
Bloody sputum .... YES NO
If yes, date of last chest x-ray____________
Loss of appetite .... YES NO
Frequent nausea/vomiting .... YES NO
Vomiting blood .... YES NO
Liver disease .... YES NO
Abdominal pain .... YES NO
Jaundice (yellow skin) .... YES NO
Change in bowel habits .... YES NO
Blood in urine .... YES NO
Incontinence .... YES NO
Painful urination .... YES NO
Kidney disease .... YES NO
Back pain .... YES NO
Arm or leg pain .... YES NO
Arm or leg weakness .... YES NO
Joint pain or swelling .... YES NO
Arthritis .... YES NO
Osteoporosis .... YES NO
Skin disease .... YES NO
Recurrent skin infections .... YES NO

Syncope (fainting) .... YES NO
Seizures .... YES NO
Memory impairment .... YES NO
Disorientation .... YES NO
Difficulty with speech .... YES NO
Inability to concentrate .... YES NO
Facial weakness .... YES NO
Lack of coordination .... YES NO
Frequent headaches .... YES NO
Anxiety .... YES NO
Depression .... YES NO
Personality change .... YES NO
Diabetes .... YES NO
Thyroid disease .... YES NO
Increeased appetite .... YES NO
Excessive thirst or urination .... YES NO
Nipple discharge .... YES NO
Anemia .... YES NO
Hemophilia .... YES NO
Bleeding tendency .... YES NO
Abnormal bruising .... YES NO
Persistent swollen glands/
lymph nodes .... YES NO
Immunologic disorder .... YES NO

If you answered yes to any of the above, please explain:

____

____

____

SOCIAL HISTORY

Do you have any children? ☐Yes ☐No If yes, how many?______

Do you live alone? ☐Yes ☐No

If no, who lives with you?_____________________________________

Choose the statement that applies to you about tobacco use:
___ Yes, I use tobacco: ☐Daily ☐One or more times per week
☐One or more times per month ☐Rarely
___ No, I do not use tobacco
___ I have a history of tobacco use

Choose the statement that applies to you about alcohol and/or drug use:
___ Yes, I drink: ☐Daily ☐One or more times per week
☐One or more times per month ☐Rarely
___ No, I do not drink
___ I have a history of alcohol and/or drug abuse

Do you drink caffeinated beverages? ☐Yes ☐No
If yes, How many cups per day?________

Do you use any illicit drugs? ☐Yes ☐No
If yes, what substance(s)?_____________________________________

Are you at risk for AIDS/HIV? ☐Yes ☐No
If yes, please explain:_____________________________________

What Physician requested your consultation?
Doctor's name: _____________________________________
Address: _____________________________________
Phone number: _____________________________________

Who is your primary care / family phsician?
Doctor's name: _____________________________________
Address: _____________________________________
Phone number: _____________________________________

Please list other physicians you have seen for your problem
(names, addresses, and phone numbers):

____

____

____

____

Is there any special information the doctor should know about you that has not already been addressed?
(i.e., do you have a pacemaker, rare blood disorder) ☐Yes ☐No

If yes, please explain: _____________________________________

____

The information provided above is accurate to the best of my knowledge:

Patient Signature ______________________________________ Date: ____________________

I have reviewed the information above with the patient:

Physician's Signature ______________________________________ Date: ____________________