

**Advanced PMR  
Personal Injury Patient Intake**

GENERAL INFORMATION

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status:  
S M D W Drivers License Number and State issued \_\_\_\_\_ State \_\_\_\_\_  
As a convenience to our patients, we offer appointment reminders through emails and text messages.  
Would you like to be set up on automatic text reminders?  Yes  No If yes, who is your cell phone  
provider? \_\_\_\_\_

ACCIDENT INFORMATION

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other  
Date of Accident \_\_\_\_\_ Has the accident been reported?  Yes  No  
To Whom? \_\_\_\_\_ Claim Number \_\_\_\_\_

HEALTH INSURANCE INFORMATION

Name of Your Health Insurance Co. \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name if different than yours \_\_\_\_\_ Insured's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_

SECONDARY INSURANCE INFORMATION

Name of Your Health Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_  
Group # \_\_\_\_\_ Insured's Name if different than yours \_\_\_\_\_  
Insured's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Insured \_\_\_\_\_  
Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Signature of Patient/or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

ACCIDENT INFORMATION

Is this visit related to the auto accident  Yes  No If so, when was the date of the accident

\_\_\_\_\_

Please describe in detail the accident (use the back of this sheet if needed):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please answer the following questions about the accident:

1. Were you the  driver  the passenger  a pedestrian  on a bicycle  on a motorcycle
2. Were you  hit (by another vehicle) or  at fault (you caused the accident)?
3. From which side were you struck  behind  the front  the right side  the left side  the right front  the left front  the right back  the left back.
4. At the time of impact were you  stopped  moving  walking  standing still  running  bicycling  riding a motorcycle  crossing the street.
5. Were you moving at the time of the accident  yes or  no? If yes, what was your speed \_\_\_\_\_?
6. Was the involved party moving when the accident occurred  yes or  no, If yes what was their speed \_\_\_\_\_?
7. Did you have your seatbelt on at the time of the accident  yes  no?
8. Was your head turned at the time of the accident  yes or  no, If yes were you looking  forward  looking to the right  looking to left  looking behind you  looking up  looking down.
9. Were you alone at the time of the accident  yes or  no? If no who was with you \_\_\_\_\_?
10. What parts of your body hit other structures at the time of impact  head  face  forehead  back of head  right TMJ  left TMJ  right shoulder  left shoulder  right arm  left arm  right elbow  left elbow  right wrist  left wrist  right hand  left hand  Right leg  left leg  right knee  left knee  right ankle  left ankle  right foot  left foot
11. What structures did you hit?  steering wheel  windshield  side window  door  roof  dashboard  headrest  seat  floor  Side of car  hood of car  bumper  trunk  the pavement  tree  another car  another person  another object  a wall
12. How did you feel after the collision?  stunned  disoriented  lost consciousness  tightness  felt mild discomfort  felt moderate discomfort  felt severe discomfort  felt intense pain  frightened  felt a popping and ripping sensation  went to hospital
13. Who was cited for the accident  me  other driver
14. Have you had one or more of the following symptoms since your accident?  Cannot sleep due to the accident  having trouble getting to sleep since the accident  Lost time from work due to the accident  have been depressed since the accident occurred
15. Have you been treated for injuries related to the accident already?  yes  no If yes, by whom? \_\_\_\_\_ Did they perform any diagnostic testing?  yes  no
16. Have you lost wages or not been able to work due to the accident?  yes  no

### HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) \_\_\_\_\_

Please check to indicate if you are currently experiencing any of the following conditions:

- |                                              |                                                |                                             |                                                |                                     |
|----------------------------------------------|------------------------------------------------|---------------------------------------------|------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Eczem      |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

Please check to indicate if you are currently experiencing any of the following:

- |                                             |                                              |                                             |                                               |                                             |
|---------------------------------------------|----------------------------------------------|---------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        | _____                                       |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Stroke               | _____                                       |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Suicide Attempt      | _____                                       |

Are you currently pregnant?  Yes  No

Are you currently under drug and/or medical care?  Yes

No If yes, explain \_\_\_\_\_

Please list any medications you are currently taking (Be sure to include dosage and frequency)

\_\_\_\_\_  
Please list any surgeries and/or hospitalizations you have had (type & date)

\_\_\_\_\_  
If you are male, when was your last prostate exam? \_\_\_\_\_

Normal prostate results? \_\_\_\_\_

Please list any supplements you are currently taking (vitamins, minerals, herbs) \_\_\_\_\_

Are you currently on any blood thinners – (aspirin regimen included)?  Yes  No

List Type \_\_\_\_\_

**Contraindications: A few Procedures in the office should be avoided if patients have certain conditions.**

Please CHECK if you have any of the following:  Type 2 Diabetes  Sleep Apnea  High Cholesterol

A pacemaker  Suffer from blood clots  Local or systemic infection  Allergies (please list)

\_\_\_\_\_  Atria Fibulation  Uncontrolled Hypertension  Glaucoma  Rapid Heartbeat

Severe Depression  Uncontrolled clotting disorder  Renal Disease  Pregnant/Breast Feeding  History of Stroke  Hyperthyroid  History of Drug/Alcohol Abuse Is there a family history of any of the

following conditions? (Indicate family member including parents, grandparents & siblings)  Heart Disease

\_\_\_\_\_  Diabetes \_\_\_\_\_  Stroke \_\_\_\_\_  Cancer

\_\_\_\_\_  Arthritis \_\_\_\_\_  Other \_\_\_\_\_

Do you exercise?:  Yes  No How often?: 1X 2X 3X 4X 5X per week Other: \_\_\_\_\_

Which activities:  Running  Jogging  Weight Training  Cycling  Yoga  Pilates  Swimming  Other

\_\_\_\_\_  
Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

What is your daily/weekly intake of the following: Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_

drinks/week Energy Drinks \_\_\_\_\_ cups/day Cigarettes \_\_\_\_\_ packs/day

**I hereby certify that the previous questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.**

Patient's / Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Reviewed Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Updated Signature \_\_\_\_\_ Date \_\_\_\_\_

### **RADIOGRAPH CONSENT**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition.

By signing below, you give your consent to allow Advanced Physical Medicine & Rehab and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant \_\_\_\_\_ ( Initial ) Signature of Patient/or

Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

### **AUTHORIZATION OF CARE**

This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom

cause any problem. In rare cases, 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 these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc). I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also clearly understand that if I do not follow the Doctors and/or physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physician for all services rendered. I understand in the event my account goes to collections, I am responsible for any and all collections fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

NAME OF GUARANTOR (person responsible for guaranteeing payment for all services)

\_\_\_\_\_

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient's Name Printed \_\_\_\_\_

Date \_\_\_\_\_

Patient's signature \_\_\_\_\_

Date \_\_\_\_\_

Minors Name \_\_\_\_\_

Guardian/Spouse's Signature of Authorizing care for minor \_\_\_\_\_

Date \_\_\_\_\_

I hereby authorize Advanced Physical Medicine and Rehab to administer care as deemed necessary to my child, a minor under the age of 18 years old.

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT (CONSENT TO USE PHI)**

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Advanced Physical Medicine & Rehab or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

**Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

*By my signature below I give my permission to use and disclose my health information.*

Patient or Legally Authorized Individual Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Patient's Full Name \_\_\_\_\_

Time of Day \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_