Welcome

1 About you

TODAY'S DATE: ___/___/___ FILE # ______

PATIENT NAME: ______
LAST FIRST MI

WHAT YOU PREFER TO BE CALLED ______ ❑ MALE ❑ FEMALE

BIRTHDATE: ______ AGE ____ SS# ______

MAILING ADDRESS: ______

______
CITY STATE ZIP

HOME PHONE #: ______

WORK PHONE #: ______ EXT ______

OTHER PHONE #: ______

EMAIL ADDRESS: ______

EMPLOYER: ______ HOW LONG? ____

EMPLOYERS ADDRESS: ______

______

______
CITY STATE ZIP

OCCUPATION: ______

STATUS: MINOR SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSES NAME: ______

DO YOU HAVE KIDS? YES NO HOW MANY ______

2 Insurance Info

CO. NAME: ______

ADDRESS: ______

PHONE#: ______

INSUREDS SS#: ______

GROUP# (PLAN, LOCAL OR POLICY#)

INSURED'S NAME: ______

RELATION: ______

DATE OF BIRTH ___/___/___

INSURED'S EMPLOYER: ______

______

PLEASE INFORM FRONT DESK OF 2ND. INSURANCE SOURCE

3 REASON FOR VISIT

THE REASON FOR THIS VISIT IS A RESULT OF: (PLEASE CIRCLE): WORK SPORT AUTO TRAUMA OR CHRONIC

(EXPLAIN WHAT HAPPENED): ______

______

______

PLEASE DESCRIBE THE PAIN & ITS LOCATION : ______

______

WHEN DID THIS CONDITION BEGIN? ___/___/___

IS THIS CONDITION GETTING WORSE?

YES NO CONSTANT COMES & GOES

IS THIS CONDITION INTERFERING WITH YOUR: (PLEASE CIRCLE) WORK SLEEP OR DAILY ROUTINE

IF SO PLEASE EXPLAIN : ______

______

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR THIS CONDITION ? YES NO

IF SO WHERE ? ______

4 IN EVENT OF EMERGENCY

Who should we contact? : ______________________________

Relation : ______________________________

Home phone# : ______________ Work phone#: ______________

Who is your Medical Doctor? ______________ phone#: ______________

5 HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants ❑ Blood thinners ❑ Tranquilizers ❑ Insulin

❑ Others ______________________________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Dizziness	Y N Jaw Problems	Y N Leg pain
Y N Congenital Heart Defect	Y N Mitral valve Prolapse	Y N Artificial Valves	Y N Difficulty sleeping	Y N Irritability	Y N Ears ringing
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N Nausea	Y N Back pain	Y N Stomach upset
Y N HIV+/ Aids	Y N Shingles	Y N Cancer	Y N Arm/Shoulder pain	Y N Headaches	Y N Numb Feet/Toes
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia	Y N Fatigue	Y N Numb Hands/Fingers	Y N Neck pain
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Blurred vision	Y N Lower back pain	Y N Memory loss
Y N Severe Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis	Y N Back stiffness	Y N Tension	Y N Arthritis
Y N Fainting/Seizures/Epilepsy	Y N Sinus problems	Y N Asthma	Y N Shortness of breath	Y N Chest pain	Y N Artificial Bones / Joints
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy	Y N Neck stiff	Y N Buzzing in ear	Y N Lower Back Problems

Please list any other serious medical condition(s) you have or ever had: ______________________________

Please list anything that you may be allergic to: ______________________________

List previous surgeries / treatments with dates: ______________________________

____

____

List any past serious accidents with dates: ______________________________

Family Health History: ______________________________

____

Do you: Take supplements or vitamins? ❑ Yes ❑ No / Exercise ❑ Yes ❑ No

Are you on a special diet ❑ Yes ❑ No / Since ____/____/____

Do you Smoke? ❑ Yes ❑ No / How much __________ How long _____

Are you wearing Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports

For women:

Are you taking Birth Control? ❑ Yes ❑ No

Are you pregnant? ❑ No ❑ Yes / How Long?

Nursing? ❑ Yes ❑ No

■ I AGREE TO PAY FOR SERVICES RENDERED TO THE ABOVE MENTIONED PATIENT AS THE CHARGES ARE INCURRED. I UNDERSTAND AND AGREE THAT HEALTH & ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL SERVICES COVERED OR NON-COVERED. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED WILL BE IMMEDIATELY DUE AND PAYABLE. THE INJURIES / ILLNESS SUSTAINED AND THE PAIN AND SUFFERING I HAVE ARE REAL AND I HAVE NOT EITHER IMAGINED OR EXAGGERATED THE EXTENT AND NATURE OF MY PAIN AND SUFFERING OR ILLNESS.

■ I AM OF SOUND MIND, AND TO THE BEST OF MY KNOWLEDGE ALL THE INFORMATION I HAVE PRESENTED IS TRUE. I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER AND OR MANAGED CARE ORGANIZATION, TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

SIGNATURE ______________________________

PAIN CHART

About you

PATIENT NAME: ______________________________ FILE # ______________

WHAT IS YOUR CURRENT WEIGHT: _____ LBS, AND HEIGHT _____FT_____IN.

PLEASE DESCRIBE YOUR CONDITION: ______________________________

____

____

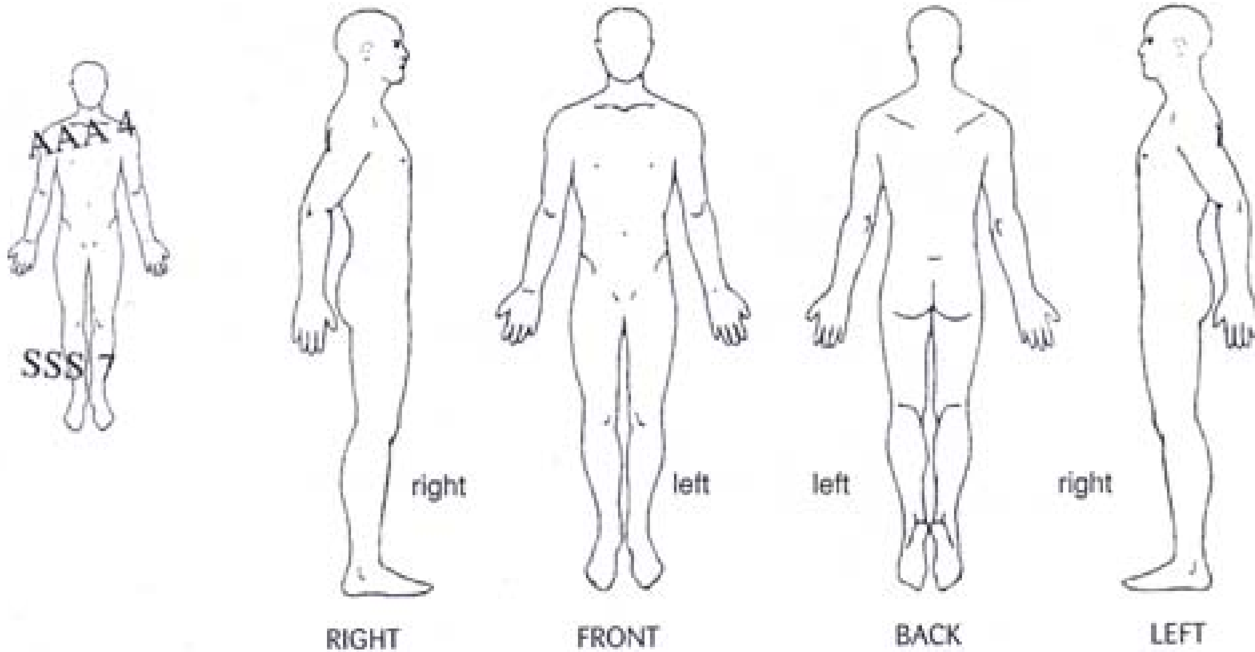
____

SIGNATURE ______________________________ DATE ______________

Show us where it hurts

PLEASE MARK **AREA(S)** OF INJURY OR DISCOMFORT AS SHOWN IN THE EXAMPLE BELOW. MARK ALL AREAS WITH THE APPROPRIATE SYMBOLS AND INDICATE THE DEGREE OF PAIN USING A SCALE: FROM 1 (DISCOMFORT) TO 10 (EXTREME PAIN).

DESCRIPTION	NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
SYMBOL	NNN	PPPP	BBBB	AAAA	SSSS



Doctors Notes

____

____

____

____

____

____

____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type	2. Your position in vehicle	3. What was your vehicle doing at the time of the accident?
❑ Car ❑ Station Wagon ❑ Van ❑ Pickup Truck ❑ Large Truck ❑ Bus Other________	❑ Driver ❑ Front Passenger ❑ Left Rear Passenger ❑ Right Rear Passenger Other________	❑ Stopped at intersection ❑ Stopped in traffic ❑ Stopped at light ❑ Making a right turn ❑ Making a left turn ❑ Parking ❑ Proceeding along ❑ Slowing down ❑ Accelerating Other________

4. Time/Speed/Damage	5. Details of Accident	6. Road conditions
Time of accident________ Your vehicle's speed: ________mph Their vehicle's speed: ________mph **Damage to your vehicle** ❑ Mild ❑ Moderate ❑ Totaled	**Visibility at time of accident** ❑ Poor ❑ Fair ❑ Good **Who hit who/what?** ❑ You hit other vehicle ❑ Other vehicle hit you **You hit...(object)** ________	**Road conditions at time of accident** ❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and dry **Point of impact** ❑ Head-On ❑ Left Front ❑ Right Front ❑ Read-End ❑ Left Rear ❑ Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes** ❑ ❑ **No** Were you braced for the impact? **Yes** ❑ ❑ **No** Did you have a seat belt on? **Yes** ❑ ❑ **No** Did you have a shoulder harness on? **Yes** ❑ ❑ **No**	**Does your vehicle have headrests? Yes** ❑ ❑ **No** **What was the position of your headrest at the time of the impact?** ❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck **What was the direction of your head at the time of the impact?** ❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side air bags deploy? **Yes** ❑ ❑ **No** Did passenger side airbags deploy? **Yes** ❑ ❑ **No** Did side airbags deploy? **Yes** ❑ ❑ **No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:	10. After the accident:
Did your body strike the inside of your vehicle? **Yes** ❑ ❑ **No** If yes, describe:________ Did you lose consciousness during the injury? **Yes** ❑ ❑ **No** If yes, for how long?________ Your vehicle's estimated damage?________ **Damage to their vehicle:** ❑ Mild ❑ Moderate ❑ Totaled Did police show up at the scene? **Yes** ❑ ❑ **No** Was an accident report filled out? **Yes** ❑ ❑ **No**	**Check off your symptoms right after and a few days following:** ❑ Headache ❑ Dizziness ❑ Mid back pain ❑ Cold hands ❑ Neck pain ❑ Nausea ❑ Low back pain ❑ Cold feet ❑ Neck stiffnes ❑ Confusion ❑ Nervousness ❑ Diarrhea ❑ Fainting ❑ Fatigue ❑ Loss of taste ❑ Depression ❑ Ringing in ears ❑ Tension ❑ Toe numbness ❑ Anxious ❑ Loss of smell ❑ Irritability ❑ Constipation ❑ Chest Pain ❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping problems Others:________

11. Emergency Room?	12. Treatment History:
Where did you go after the accident? ❑ Home ❑ Work ❑ Hospital ER ❑ Private Doctor **How did you get there?** ❑ Drove self ❑ Somebody else ❑ Ambulance ❑ Police **Were X-rays done?** Yes ❑ ❑ No **Was lab work done?** Yes ❑ ❑ No Body parts X-rayed?________ What lab work?________ The X-rays revealed:________ **Treatments:** ❑ Cervical Collar ❑ Ice **Other:**________ Medications:________ Follow-up instructions:________ ________	**Fill in any other doctor(s) seen prior to your first visit to this office.** **1. Dr.** ________ First visit date: ___/___/___ Specialty:________ X-rays done? **Yes** ❑ ❑ **No** Types of treatments received:________ How many treatments received?____ Currently treating? **Yes** ❑ ❑ **No** Did treatments benefit you? **Yes** ❑ ❑ **No** Last visit date: ___/___/___ **2. Dr.** ________ First visit date: ___/___/___ Types of treatments received:________ How many treatments received?____ Currently treating: **Yes** ❑ ❑ **No** Did treatments benefit you? **Yes** ❑ ❑ **No** Last visit date: ___/___/___

(c) 2002 Report Master, Inc. All rights reserved.

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing .... ___	Drying hair .... ___	Brushing teeth ..... ___	Putting on shoes ..... ___	Preparing meals ..... ___	Taking out trash... ___
Showering ..... ___	Combing hair .... ___	Making bed .... ___	Tying shoes .... ___	Eating .... ___	Doing laundry ..... ___
Washing hair .. ___	Washing face .... ___	Putting on shirt .... ___	Putting on pants ..... ___	Cleaning dishes ..... ___	Going to toilet ..... ___

Difficulties with Physical Activities

Standing .... ___	Walking .... ___	Kneeling .... ___	Bending back .... ___	Twisting left .... ___	Leaning back ..... ___
Sitting .... ___	Stooping .... ___	Reaching .... ___	Bending left .... ___	Twisting right .... ___	Leaning left .... ___
Reclining .... ___	Squatting .... ___	Bending forward .. ___	Bending right .... ___	Leaning forward ..... ___	Leaning right .... ___

Standing for long periods .... ___ Sitting for long periods ...... ___ Walking for long periods ...... ___ Kneeling for long periods ..... ___

Difficulties with Functional Activities

Carrying small objects .... ___	Lifting weights off floor .... ___	Pushing things while seated .... ___	Exercising upper body .... ___
Carrying large objects .... ___	Lifting weights off table .... ___	Pushing things while standing .. ___	Exercising lower body .... ___
Carrying brief case .... ___	Climbing stairs .... ___	Pulling things while seated .... ___	Exercising arms .... ___
Carrying large purse .... ___	Climbing inclines .... ___	Pulling things while standing .... ___	Exercising legs .... ___

Difficulties with Social and Recreational Activities

Bowling .... ___	Jogging .... ___	Swimming .... ___	Ice Skating .... ___	Competitive Sports . ___	Dating .... ___
Golfing .... ___	Dancing .... ___	Skiing .... ___	Roller Skating .... ___	Hobbies .... ___	Dining out .... ___

Difficulties with Travelling

Driving a motor vehicle .... ___	Riding as a passenger in a motor vehicle ..... ___	Riding as a passenger on a train .... ___
Driving for long periods of time .... ___	Riding as a passenger on an airplane .... ___	Riding as a passenger for long periods ...... ___

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating....____ Hearing....____ Listening....____ Speaking....____ Reading....____ Writing....____ Using a keyboard....____

Difficulties with the Senses

Seeing........____ Hearing........____ Sense of touch........____ Sense of taste........____ Sense of smell........____

Difficulties with Hand Functions

Grasping........____ Holding........____ Pinching........____ Percussive movements........____ Sensory discrimination........____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep........____ Being able to participate in desired sexual activity........____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms	**Has your History Contributed to your Current Symptoms?**
☐ I have NOT had prior symptoms similar to my current complaints.	☐ My history HAS contributed to my current symptoms.
☐ My current complaints DID exist before, but have not been bothering me.	☐ My history HAS NOT contributed to my current symptoms.
☐ My current complaints ALREADY existed and were worsened.	☐ I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (**if applicable**) occured........____ ☐ months ago / ☐ years ago **Or on** Date: ____/____/____

Write in below any other Prior Symptom History, not covered above:

(c) 2002 Report Master, Inc. All rights reserved.

HEALTH CARE AUTHORIZATON FORM

Patient's Name____________________________
Patients SS#_______________ Date of Birth____________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES DR. ANTHONY R. BARTOLO, COBB PAIN AND REHABILITATION TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS (please check all that apply)

☐ I give permission to Cobb Pain & Rehabilitation, to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information. I also give permission allowing my name to be posted on a referral board or my picture to be posted on message board for office related events. In the future should I write a testimonial regarding my treatment in this office, I give permission for it to be posted.

☐ If Cobb Pain & Rehabilitation, contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail, or with the individual who answers the telephone.

☐ I give Cobb Pain & Rehabilitation permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

☐ By signing this form you are giving Cobb Pain & Rehabilitation permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATON, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Cobb Pain & Rehabilitation. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request and your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Cobb Pain & Rehabilitation for its own use/disclosure of Protected Health Information. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Cobb Pain & Rehabilitation will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

** ** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU ** **

Print Name of Patient

____

Signature of Patient

____

Date

____

Signature of Personal Representative

____