New Patient Application

Welcome to Tristate Functional Wellness / Evansville Rehabilitation

For our office to better serve you, please provide the following information.

Please print

Date_____/_____/_____

Last Name_____ First Name_____ M.I._____

Nickname_____

Street Address_____ City_____ State____ Zip_____

Home Phone(____)_____-_____ Marital Status: Single Married Widow Divorced Other

Gender_____ Social Security #_____-_____-_____ Date Of Birth_____/_____/_____

Employer_____ Occupation_____

Employer Address_____ Work Phone(_____)_____-_____

Emergency Contact_____ Contact Phone(_____)_____-_____

Primary Care Physician_____ Date of Last Visit_____

Referred by:_____

Insurance Information

Primary Insurance

Insurance Company_____ Insured Name_____

ID Number_____ Group #_____

Insured Date of Birth_____/_____/_____ Relationship to insured: Self Spouse Child Other

Secondary Insurance

Insurance Company_____ Insured Name_____

Insured Employer_____ ID#_____ Group #_____

Insured Date of Birth____/_____/_____ Relationship to insured: Self Spouse Child Other

If your condition is accident related, will a claim for workmen's compensation be filed? Yes / No

For automated appointment reminders, we need all of the following information.

Email address_____

Cell Phone Number_____

Cell Phone Provider_____

Choose when you want to be reminded about your appointment:

1 hour prior 2 hours prior 1 day before 2 days before

Please list names of people and their relationship to you, that we may release your health information to:

Name_____ **Relationship**_____

Name _____ **Relationship**_____

Name _____ **Relationship**_____

Name _____**Relationship**_____

Do you currently smoke tobacco of any kind? __Yes __Never been a smoker __Former Smoker

If yes, how often do you smoke? __Current Everyday smoker __Current Some-day smoker

If yes: What is your level of interest in quitting smoking? 1 2 3 4 5 6 7 8 9 10 N/A

List current medications including dosage, if known. If no medications are currently taken then check here: __

1)_____ 2) _____

3)_____ 4) _____

5)_____ 6) _____

7)_____ 8) _____

List any known allergies that you have to any medications. If no allergies are known then check here: ___

1)_____ 2) _____

3)_____ 4) _____

What are your main health problems? Briefly list the name of your problem(s):

_____

Has any doctor diagnosed you with Hypertension presently? ___ Yes ___No If yes, what kind? _____

Has any doctor diagnosed you with Diabetes presently? ___ Yes ___No If yes, what kind? Type I or II ?

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes ___ No___ Not Sure___

Has any doctor diagnosed you with any type of significant health syndrome presently? Yes ___ No___ Not Sure__

If yes, what kind? _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? Yes _____ No ____

To be performed by clinic staff: Height:_____ ___ inches Weight: _____ pounds BP:_____/_____

Evansville Rehabilitation d/b/a/ TriState Functional Wellness
Financial Policy

It is the goal of TriState Functional Wellness to render the highest quality health care to our patients. We will verify your benefits with your insurance company at the time of your visit. This is not a guarantee of payment by them but it lets us be aware of your coverage and benefits. If your insurance changes it is critical for us to know so we may contact the new carrier concerning your new policy. Please review the following statements so that you will have a clear understanding of our procedures so we may serve you better.

- As a service to you, our office will file your claims with your primary insurance company.
- Claims for any secondary insurance coverage are to be filed by you. Full payment for the amount of secondary insurance coverage is still expected at the time of service.
- THE PATIENT IS RESPONSIBLE FOR MONITORING THEIR NUMBER OF VISITS.
- Co-payments and un-met deductibles are to be paid at the time of service.
- Any service not covered by your insurance company will be your financial responsibility.
- Any service incurred after you have reached your benefit maximum is considered a non-covered service. Therefore, we are not obligated to take the insurance discount normally written off for covered services. You are responsible for the full amount charged.
- TriState Functional Wellness accepts cash, personal checks, Visa, Discover or MasterCard.
- It is necessary to keep your balance current. If your balance exceeds $200.00, a payment will be required before another appointment can be scheduled for you or a family member unless you have made special arrangements with the billing department concerning your account. A monthly plan may be arranged with the insurance department.
- Insurance is a contractual agreement between you and your insurance company. Our office will not enter into a dispute with your insurance company or attorney concerning your coverage.
- You will immediately notify our office of any change in your insurance coverage.
- You may be charged $25.00 if you do not call to cancel your appointment at least four hours prior to the given appointment time.
- In the event that you have an account become delinquent and are referred to an outside collection agency, you will be responsible for all collection fees, legal fees, and court costs incurred.

I understand and agree that health and accident insurance policies are an arrangement between myself and the insurance carrier and that I am personally responsible for payment of any and all services, covered or non-covered. I hereby authorize EVANCVILLE REHABILITATION, PC to furnish information to all insurance carriers or other health care providers concerning my treatment and I hereby assign to the practitioners all payments for services rendered to my dependents or myself

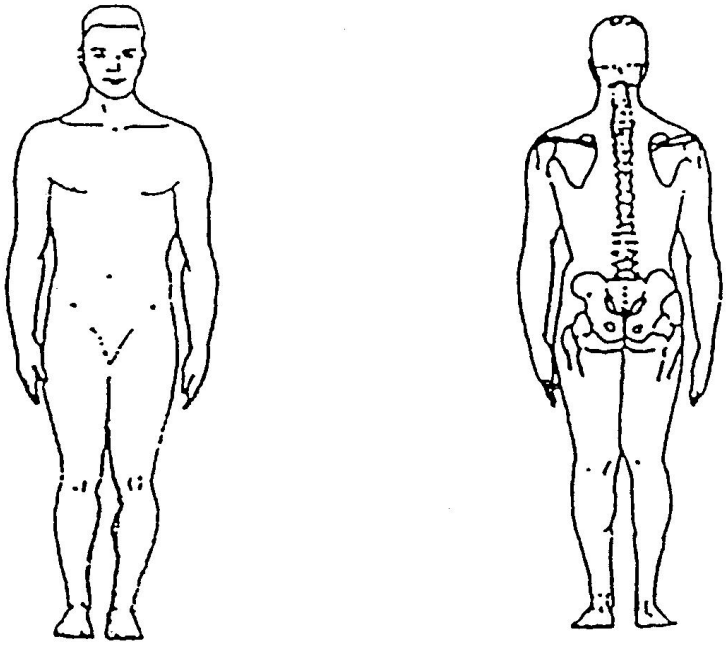
_____ _____

Signature Date

Parent or Guardian's Signature_____ Date_____

Chief Complaint and History of Present Condition **Patient Name**_____

1. Where is your pain (indicate on figures) If it is more than one area, **NUMBER in order of priority with the worst first.**



2. What type of pain is it? Indicate which number/area has which type of pain

_____Sharp _____Ache _____Dull _____Burning _____Throbbing

3. Rate pain on a scale of 0-10 (10 being severe pain): 1)_____ 2)_____ 3)_____ 4)_____

4. How long have you had this pain?

   1)_____ 2)_____

   3)_____ 4)_____

5. What makes the pain worse?

   1)_____ 2)_____

   3)_____ 4)_____

6. What makes the pain better?

   1)_____ 2)_____

   3)_____ 4)_____

7. Does the pain travel?_____ If so, where?_____

8. Is pain worse at any particular time of day? _____

TriState Functional Wellness / Evansville Rehabilitation Health Questionnaire

Patient Last Name_____ Current Date_____

1) List any other doctors that you have seen and list treatments received and results obtained:

2) List all diagnostic testing (x-rays, MRI's, blood and urine analysis, etc) that you have received:

3) List all surgeries you have had and the corresponding dates

4)) Please mark with an "X" the following which you have been taking within the past 2 months:

Vitamins _____ _____ _____ _____

_____ _____ _____ _____

Over the counter meds_____ _____ _____

Others_____Others_____

5) Is your current condition accident related? Y N Date of Accident_____

Type of accident Auto Work/Job At home Other_____

6) Have you ever been in an automobile accident?

_____Past Year ____Past 5 Years ___Over 5 years ago ___Never

Were there any injuries? Yes/No If yes, explain_____

_____

7)Have you ever sustained an industrial injury or any other injury for which you received treatment? Yes/No

When?_____ What was your injury?_____

9)Please check the following conditions that you have or have had:

___AIDS	___Hardening of the arteries	___Polio
___Anemia	___Heart Attack	___Rheumatic Fever
___Arthritis	___High blood pressure	___Stroke
___Cancer	___Hypoglycemia	___Tuberculosis
___Diabetes	___Multiple Sclerosis	___Venereal Disease
___Epilepsy	___Parkinson's Disease	

	Current Age	Age at Death	Health Problems/Cause of Death (if applicable)
Mother:			
Father:			
Siblings:			
Children (Names):			

Please Mark with an X all symptoms:

Head
___Unusually frequent headaches
Frequency _____
Location _____
Type_____
___Head feels heavy
___Vertigo
___Light-headedness
___Loss of Smell
___Loss of Taste
___Loss of balance
___Previous head trauma or concussion

Neck Pain
Right, Left or Both (circle one)
___Neck pain with movement
___Swelling in neck
___Stiff Neck
___Pinched Nerve in neck
___Neck feels out of place
___Muscle spasms in neck
___Abnormal sounds in neck
___Previous neck injury
___Radiating arm pain
___Numbness or tingling in arm.

Shoulders
___Pain in shoulder (right or left)
___Pain across shoulders
___Tension in shoulders
___muscle spasms in shoulders
___Can't raise arm above shoulder level
___Can't raise arm over head

Arms and Hands
___Pain in upper arm
___Pain in forearm
___Pain in hands
___Pain in fingers
___Sensation of pins and needles
(__in arms (R / L)
(__in fingers (R / L)
___Fingers go to sleep
___Hands cold
___Swollen finger joints
___Sore finger joints
___Loss of grip strength

Mid Back
___Pain between shoulder blades
___Mid-back pain
___Pain from front to back
___Pain over kidney area (R / L)
___Muscle spasms in mid back

Low Back
___Low back pain (R / L)
___Low back feels out of place
___Muscle spasms in low back

Hips, Legs & Feet
___Pain in buttocks (R / L)
___Pain down leg (R / L)
___Knee Pain (R / L)
___Leg cramps (R / L)
___Pins and needles sensation (R / L)
___Numbness in leg (R / L)
___Numbness in toes (R / L)
___Cold feet
___Swollen ankles
___Swollen feet

Cardiovascular
___General swelling
___Swelling in legs
___Swelling in face
___Swelling around eyes
___Chest pain
___Pounding heartbeat
___Heart "jumps"
___Rapid heartbeat
___Irregular heartbeat
___Blue or purple skin
___Fainting
___Hypertension

Hair, Skin, Nails
___Baldness
___Dry scalp
___Oily scalp
___Eczema
___Psoriasis
___Itchy skin
___Rough, scaly skin
___Dry skin
___Oily skin
___Yellow skin
___Bruise easily
___Pale skin
___Paper-thin nails
___Nail biting

Eyes
___Blurred vision
___Double vision
___Eyes fatigue easy
___Excessive tearing
___Lack of tearing
___Light bothers eyes
___Excessive itching
___Pain in eyeball
___Periods of blindness in eye

Ears
___Loss of hearing (R / L)
___Pain in ears (R / L)
___Vertigo
___Ringing in ears (R / L)
___Discharge from ears (R / L)

Nose/Nasopharynx/Sinuses
___Unusual nasal discharge
___Nosebleeds
___Pressure over eyes
___Pressure under eyes
___Obstruction of nose
___Frequent colds
___Sinusitis
___Nasal allergies (Seasonal or year round)
___Loss of sense of smell
___Any trauma to nose

Mouth & Throat
___Pain in mouth
___Pain in throat
___Bleeding gums
___Cavities
___Abscessed teeth
___Dentures
___Difficulty in swallowing
___Changes in voice

Respiratory
___Shortness of breath
___Difficulty breathing lying down
___Difficulty sleeping lying down
___Dry cough
___Productive cough
___Coughing up blood
___Wheezing

Gastrointestinal
___Poor appetite
___Constant nibbling
___Indigestion (How often? _____)
___Stomach upsets from food
___Stomach upsets from liquid
___Stomach upsets from medicines
___Abdominal Pains (Where?_____)
___Stomach gas before meals
___Stomach gas with meals
___Stomach gas after meals
___Change in bowel habits
___Diarrhea
___Constipation
___Hemorrhoids

Genitourinary
Urination is: Frequent / Infrequent
Amount is: High / Low?
___Painful urination
___Difficult to start/stop urination
___Dribbling
___Blood in urine
___Lack of bladder control
___Need to get up at night to urinate (Times: _____)
___Cloudy urine

Female Only
Do you have regular periods? (Y / N)
___Painful period
___Spotting
___Vaginal discharge (Color?_____)
___Premenstrual Symptoms?
_____
___Irregular periods
___Lumps in breast
___Wear an IUD
___#of pregnancies
___# of deliveries
___# of Vaginal deliveries
___# of C-sections
___complicated deliveries

Male Only
___Impotence
___Testicular swelling / pain
___Abnormal discharge

General Health Questions: ___Smoker (How many packs per day?_____ How many years_____?
___Other Tobacco use (How many cans per day?_____)
___Alcohol consumption (How many drinks per week?_____
___Coffee /tea(Cups per day?_____)
My diet is ___balanced ___not balanced What isn't balanced?_____
My rest is ___sufficient ___insufficient Why?_____
My recreation is ___sufficient ___insufficient Why?_____
My family stress is ___severe (Why?_____) ___moderate ___minimal ___none
How do you like your work? ___I like it very much ___Its okay ___I dislike it
My job stress is ___severe (Why?_____) ___moderate ___minimal ___none
I have experienced ___nervousness ___irritability ___fatigue ___depression ___run-down feeling
___craving for sweets ___craving for salt