New Patient Application

Welcome to Tristate Functional Wellness / Evansville Rehabilitation

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

Date _____

Last Name_____ First Name_____ M.I._____

Nickname_____ Email _____

Street Address_____ City_____ State____ Zip_____

Cell Phone _____ Marital Status: ◯ Single ◯ Married ◯ Widow ◯ Divorced ◯ Other

Gender _____ Social Security #_____ Date Of Birth _____ Age _____

Email Address _____

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

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

Patient Name _____

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 Ⓘ or Ⓘ ?

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:_____/_____

Patient Name _____

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, the Clinic 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 $250.00, 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 must Immediately notify our office of any change in your insurance coverage.
- You will be charged $50.00 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 Evansville 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.

I/We understand that If any unpaid balance Is assigned to a third party collection agency for collection or placed with an attorney to obtain Judgment or otherwise satisfy payment of my account, a collection fee equal to 33.33% of the unpaid balance will be added to my account. I/We understand that Interest of 18% per annum will be charged by Evansville Rehabilitation, PC at the time my/ our account Is referred to a collection agency. I/We agree to pay that fee. I/We further agree to pay reasonable attorney fees and court costs If a Judgment Is granted against me/us.

_____ _____

Signature of Responsible Party *Date*

_____ _____

Signature of Parent or Guarantor Date of Birth

Please feel free to speak with our insurance department If you have questions at any time concerning your account.

Chief Complaint And History Of Present Condition **Patient Name** _____

First Complaint: _____
Pain Level (0 – 10) Now ____ At its Worst ____ On average throughout the day? _____
Is the pain Getting Better? ☐ Worse? ☐ Same? ☐
When did the problem start? _____
What caused the problem? _____
What has made the problem worse? _____
What has made the problem better? _____
Does the pain travel? _____
Is the pain worse at any particular time of day? _____

Second Complaint: _____
Pain Level (0 – 10) Now ____ At its Worst ____ On average throughout the day? _____
Is the pain Getting Better? ☐ Worse? ☐ Same? ☐
When did the problem start? _____
What caused the problem? _____
What has made the problem worse? _____
What has made the problem better? _____
Does the pain travel? _____
Is the pain worse at any particular time of day? _____

Third Complaint: _____
Pain Level (0 – 10) Now ____ At its Worst ____ On average throughout the day? _____
Is the pain Getting Better? ☐ Worse? ☐ Same? ☐
When did the problem start? _____
What caused the problem? _____
What has made the problem worse? _____
What has made the problem better? _____
Does the pain travel? _____
Is the pain worse at any particular time of day? _____

Fourth Complaint: _____
Pain Level (0 – 10) Now ____ At its Worst ____ On average throughout the day? _____
Is the pain Getting Better? ☐ Worse? ☐ Same? ☐
When did the problem start? _____
What caused the problem? _____
What has made the problem worse? _____
What has made the problem better? _____
Does the pain travel? _____
Is the pain worse at any particular time of day? _____

Patient Name _____

TriState Functional Wellness / Evansville Rehabilitation Health Questionnaire

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)) List which supplements you have been taking within the past 2 months:

Supplements _____ _____ _____ _____

_____ _____ _____ _____

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?_____

8) check any of the following 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	

Patient Name _____

	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 joint
- ___ Sore finger joint
- ___ 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

Patient Name _____

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 swallowin
- ☐ Changes in voice

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty breathing lying dow
- ☐ Difficulty sleeping lying dow
- ☐ 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 urinatio
- ☐ 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 ☐ insufficien 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