INTEGRATIVE PHYSICAL MEDICINE

Injury Intake
Integrative Physical Medicine

First Name: _____ Middle Initial: _____ Last Name: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Address: _____ City: _____

State _____ Zip: _____ E-mail Address: _____

SS#: ___-___-___ Age: _____ DOB: __ __ /__ __ /__ __ Male / Female

Primary Care Physician Name: _____ Physician Phone Number: _____

ACCIDENT INFORMATION: Date of Accident: _____ Where (Street/Intersection): _____

Were any tickets issued and to whom? _____

Were you the: ☐ Driver ☐ Front Seat Passenger (Right) ☐ Back Seat LEFT Passenger ☐ Back Seat RIGHT Passenger

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Left Side ☐ Right Side

Did the air bag deploy? ☐ Yes ☐ No Did you hit anything inside the vehicle? ☐ Yes ☐ No If yes, describe: _____

Did you experience immediate pain? ☐ Yes ☐ No Did the ambulance/paramedics arrive at the scene? ☐ Yes ☐ No

Were you taken to the hospital? ☐ Yes ☐ No Did you drive to the hospital? ☐ Yes ☐ No Which hospital? _____

Were x-rays taken? ☐ Yes ☐ No MRI? ☐ Yes ☐ No CT? ☐ Yes ☐ No Did they prescribe medication? ☐ Yes ☐ No

Are you currently taking medication? ☐ Yes ☐ No If yes, please name all: _____

Please describe the accident in your own words: _____

_____

FIRST (MAJOR) COMPLAINT: _____

Date when symptoms first appeared: _____ Have you had this condition before? _____

Did it begin Gradual? ☐ Yes ☐ No Sudden? ☐ Yes ☐ No How long has it been going on? _____

What makes symptoms increase? _____ What relieves symptoms? _____

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing How much of your day is pain? ☐10% ☐25% ☐50% ☐100%

Pain Intensity (circle): NONE 0 1 2 3 4 5 6 7 8 9 10 SEVERE

Does pain radiate into your (circle): L R Shoulder/Arm/Hand L R Buttocks/Leg/Foot Does not radiate

SYMPTOMS: Please check if you have experienced any of the following since this accident.

☐ Low Back Pain	☐ Tension Across Top of Shoulders	☐ Tired/Fatigued
☐ Pain between Shoulder Blades	☐ Numbness/Tingling in Arms/Hands	☐ Difficulty Sleeping
☐ Neck Pain	☐ Numbness/Tingling in Legs/Feet	☐ Ringing in Ears
☐ Difficulty talking	☐ Dizziness	☐ Brain Fog
☐ Tension/Headaches	☐ Pain in the legs/feet/buttocks	☐ Nausea
☐ Changes in Vision	☐ Pain in the hand/arm/shoulders	☐ Vomiting
☐ Difficulty swallowing	☐ Difficulty with balance	☐ Other: _____

PREVIOUS ACCIDENT HISTORY: Have you ever been involved in another motor vehicle accident? ☐ Yes ☐ No

If yes, please describe and give dates: _____

INTEGRATIVE PHYSICAL MEDICINE

Application For Patient Care

PATIENT INFORMATION

Name: _____ DOB: __ __/__ __/__ __ Date: _____

Occupation:_____ Employer:_____

Average # Hours per Week Currently Worked:_____

Type of Tasks Performed/Common Movements: _____

_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Separated ☐ Minor

Spouse's Name:_____ # of Children?_____ Children's Ages:_____

Emergency Contact Name:_____ Relation: _____ Phone #:_____

Integrative Physical Medicine can discuss my treatment with the following person/persons:_____

_____

ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Chiropractic Care? ☐ Yes ☐ No Last Visit?_____

Have You Ever Received Physical Therapy? ☐ Yes ☐ No Last Visit?_____

INSURANCE

Do you have Auto Insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Integrative Physical Medicine, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

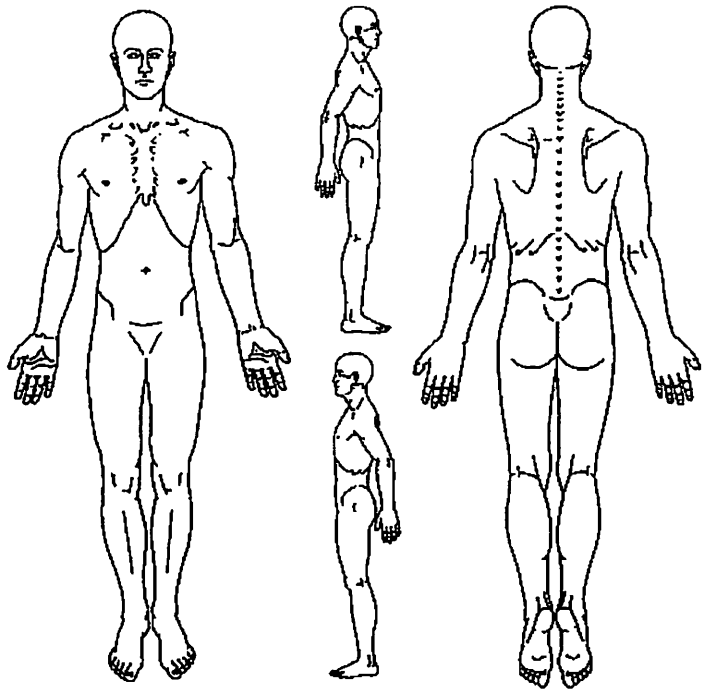
2206 E Colonial Dr.
Orlando, Florida 32803
Phone: 407-839-1045 Fax: 407-839-1044

Patient Name _____ **Date** _____

PATIENT HEALTH HISTORY

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Night Pain
- ❑ Depression
- ❑ Cold Extremeties
- ❑ Nervousness
- ❑ Sleeping Difficulties
- ❑ Jaw Problems
- ❑ Loss of Smell
- ❑ Fainting
- ❑ Dizziness
- ❑ Stomach Problems
- ❑ Asthma
- ❑ Swollen Joints
- ❑ Mood Changes
- ❑ Foot Trouble
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Light Bothers Eyes
- ❑ Recent Weigh Change
- ❑ Loss of Memory
- ❑ Nausea
- ❑ Loss of Taste
- ❑ Fatigue
- ❑ Chest Pain
- ❑ Tension
- ❑ Fever
- ❑ Cold Sweats
- ❑ Constipation/Diarrhea
- ❑ Allergies
- ❑ Shortness of Breath
- ❑ Blurred/Double Vision
- ❑ Bowel/Bladder Changes
- ❑ Trouble Concentrating
- ❑ Loss of Balance



Please check if you have ever had any of the following:

- ❑ ADD/ADHD
- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bad Breath/Bad Taste
- ❑ Bleeding Disorders
- ❑ Blood Pressure: High or Low (circle)
- ❑ Breast Lump
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Colon Trouble
- ❑ Contacts/Glasses
- ❑ Diabetes
- ❑ Dry Skin
- ❑ Ear Infections
- ❑ Epilepsy
- ❑ Fractures
- ❑ Gall Bladder
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heartburn
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Hormone/Gland Problems
- ❑ Insomnia
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Measles
- ❑ Menopausal Prob.
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mouth Sores or Bleeding Gums
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nosebleeds
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sexual Difficulty
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ TMJ Pain
- ❑ Tonsillitis
- ❑ Tremors
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other: _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any and all medications you are currently taking: _____

_____

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

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Patient Name_____ **Date** _____

ALLERGIES: (Please place a check mark next to any known allergy that you have.)

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat
___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine
___Mildew ___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen ___Insects
___Dog Dander ___Cat Dander ___Latex ___Other Animal Dander ___ OTHER: _____ *(please fill in)*

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*
❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

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

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes ____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete and accurate information during my exam.
SIGNATURE (X) _____ **DATE** _____

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____
_____

Date of last menstrual period: _____

_____ _____
Patient's Signature Date

2206 E Colonial Dr.
Orlando, Florida 32803
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INTEGRATIVE PHYSICAL MEDICINE

NEUROLOGICAL / MRI / VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE**_____

For any YES answer, please explain under comment and notify Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication? _____
12. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind? _____
13. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for? _____
    _____
14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it? _____
    _____
15. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: _____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

RECORDS RELEASE AUTHORIZATION

DATE: _____

To Doctor or Hospital

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

I hereby authorize and request release to:

Integrative Physical Medicine
2206 E. Colonial Drive
Orlando, FL 32803
Ph: (407) 839-1045
Fx: (407) 839-1044

The complete history records in your possession, concerning my illness and/or treatment during the period:

From: ____/____/_____ To: ____/____/_____

Patient: _____

SSN: _____ DOB: ____/____/_____

Patient's Signature: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Integrative Physical Medicine, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive physical medicine care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Shelby Reid. If you would like further information about our privacy policies and practices please contact: Shelby Reid.

My signature acknowledges that I permit Integrative Physical Medicine to download and access the prior 13 (Thirteen) months of my medication history through my insurance company.

This notice is effective as of December 1, 2011. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Print)	Signature	Date

INTEGRATIVE PHYSICAL MEDICINE

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

We will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, active/passive rehabilitation, chiropractic care, and/or massage therapy. 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 primary focus of care in this office is the detection and correction of Neuromusculoskeletal conditions as well as lifestyle modification for the correction or amelioration of physiological and physical ailments.

Through specific tailored treatment plans, we reduce and/or correct physical or physiological disturbances. It may be necessary to examine an individual each time a new injury occurs and often x-rays or other diagnostic procedures are necessary to maintain the utmost safety when dealing with your body. The risks of physical medicine, active/passive rehabilitation, chiropractic care, and/or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the X-rays.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to Integrative Physical Medicine, to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

FOR MINORS:

I, _____ being the parent or legal guardian of _____,
(Print Guardian Name) (Print Minor's Name)
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

_____ _____
(SIGNATURE) (DATE)

2206 East Colonial Drive
Orlando, FL 32803
P: 407-839-1045 F 407-839-1044