PROGRESSIVE REHABILITATION MEDICINE- TREATMENT APPLICATION

This treatment application is the first step in assisting the doctor in determining if you are a candidate for our non-surgical procedures, therapies, and specialized treatment technology. Please answer the following questions honestly and to the best of your knowledge.

CONFIDENTIAL PATIENT INFORMATION

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Patient First: _____ MI: _____ Last: _____ Today's Date: _____ S/S#: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone : _____ Sex: ☐Female ☐Male Birth Date: _____

Email address: _____

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

Race: _____ Ethnicity: _____ Height: _____ ft. _____ in. Weight: _____ lbs.

Occupation: _____ Please Explain Duties of Your Work: _____

Employment status: ☐Employed- full time ☐Employed- part time ☐Minor ☐Self employed

☐Student- full time ☐Student- part time ☐Retired ☐Unemployed ☐Disabled

How were you referred to our office? _____ Name of your Emergency contact: _____

Emergency contact's phone: _____ Who are they to you? _____

Who is your Primary Care Physician?: _____ City/State: _____ Phone: _____

Preferred Pharmacy: _____City/State:_____

HEALTH HISTORY

List **ALL** medications, **dosage, and frequency** that you are taking even if it's not for condition listed above OR bring a medication list on separate paper:

_____

_____

List **ALL** allergies you have including any Medication allergies:

_____

List **ALL** surgeries and dates:

_____

Why are you here today? What is your main concern? _____

Does anything relieve your pain? _____

Is it worse in the morning or as the day progresses? _____

What activities/movements are guaranteed to make it worse? _____

What positions are difficult? ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

☐Other _____

Describe on the scales below how the pain has affected your work (both inside and outside the home, and housework):

Has not affected me ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 moderate affects me☐6 ☐7 ☐8 ☐9 ☐10 extremely affects me

Please describe any other activities/hobbies that are restricted due to these symptoms.

_____

Did you have an injury or fall causing this problem and when? _____

When did you first notice these symptoms?_____ Is the condition getting worse? ☐No ☐Yes

What other doctors and kinds of treatments have you received? _____

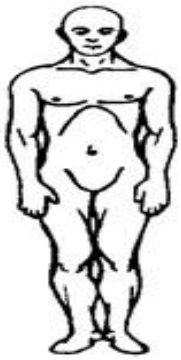
Did any of these treatments work? If so, which one(s)? For how long? _____

Have you had any: ☐Lab tests ☐X-rays ☐MRI's for this condition?

Where? _____When? _____

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= ^^^^^
Shooting	= →
Other_____	= ***



Next, please circle the appropriate number(s) for the intensity of your pain and the appropriate letter(s) for the frequency of the pain.

O = Occasional (0-25% of the time) **I = Intermittent** (26-50%)
F = Frequent (51-75%) **C = Constant** (76-100%)

Area of Pain and Intensity of Pain		Normal	Minimal	Slight			Moderate			Severe			Frequency			
													25%	50%	75%	100%
Neck			1	2	3	4	5	6	7	8	9	10	O	I	F	C
Middle Back			1	2	3	4	5	6	7	8	9	10	O	I	F	C
Lower Back			1	2	3	4	5	6	7	8	9	10	O	I	F	C
Hips	L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Arms	L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Shoulders	L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Hands	L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Legs	L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Knees	L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Feet	L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Other:			1	2	3	4	5	6	7	8	9	10	O	I	F	C

Please check any of the following that apply to **YOU**:

☐Abdominal Aortic Aneurysm ☐Severe Bleeding or Anticoagulation Therapy ☐Pacemaker/Defibrillator ☐Severe Bone Loss
☐Acute Infections ☐Benign Bone Tumors ☐Fractures or Dislocations ☐Vascular Insuffiencies
☐Hardware or Metal Implants ☐Pain Control Devices ☐Cholesterol Medications

For Women Only: Is there a possibility that you may be pregnant? ☐No ☐Yes

Do you currently have or have you previously had any of the following symptoms or conditions:

Past	Present	Condition	Past	Present	Condition	Past	Present	Conditions
☐	☐	Headaches	☐	☐	Tension	☐	☐	Ringing/Buzzing in Ears
☐	☐	Neck Pain	☐	☐	Irritability and Stress	☐	☐	Loss of Memory
☐	☐	Neck Stiffness	☐	☐	Mood Swings	☐	☐	Loss of Smell
☐	☐	Mid Back Pain	☐	☐	Sleeping Problems	☐	☐	Loss of Taste
☐	☐	Low Back Pain	☐	☐	Fatigue	☐	☐	Upset Stomach
☐	☐	Pain in Arms and/or Legs	☐	☐	Depression	☐	☐	Constipation
☐	☐	Burning on the Feet	☐	☐	Chest Pain	☐	☐	Diarrhea
☐	☐	Pins and Needles in Arms	☐	☐	Shortness of Breath	☐	☐	Urinary Problems
☐	☐	Pins and Needles in Legs	☐	☐	Cold Sweats	☐	☐	Heartburn
☐	☐	Numbness in Fingers	☐	☐	Fever	☐	☐	Ulcers
☐	☐	Numbness in Toes	☐	☐	Fainting	☐	☐	Allergies
☐	☐	Cold Hands and/or Feet	☐	☐	Dizziness	☐	☐	Menstrual Pain
☐	☐	Skin Sensitivity To Touch	☐	☐	Loss of Balance	☐	☐	Menstrual Irregularity
☐	☐	Nervousness	☐	☐	Light Sensitivity w/ Eyes	☐	☐	Hot Flashes
☐	☐	Skin Disorders	☐	☐	Loss of Vision	☐	☐	Intimacy/Sex-related Disorders

Other: _____

Have **YOU** or **A FAMILY MEMBER** ever been diagnosed with any of the following conditions:

You	Family	Condition	You	Family	Condition	You	Family	Condition
☐	☐	AIDS/HIV/Hepatitis C	☐	☐	Heart Disease	☐	☐	Thyroid Disorders
☐	☐	Cancer	☐	☐	Diabetes	☐	☐	Respiratory/COPD
☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐	Other Medical

Any condition not listed above?_____

No treatments will be rendered until we understand completely whether your condition is a good fit for our treatments and you are comfortable with our clinical approach.

If you are accepted as a patient, we will clearly help you understand your responsibility for services rendered. In cases where someone has insurance benefits, you are responsible for deductibles and copays that your insurance requires as well as any services not covered under your policy. For those without insurance or limited coverage, that is not a problem. We have easy and affordable payment options for you to get the care that you need.

Once we have enough information to determine whether or not you can be helped in our clinic, we will spend all the time necessary to help you understand your condition and what options there are to help you get better, as well as those treatments or therapies that may be available to you even outside our facility.

Thank You

_____

Signature of patient or responsible party

_____

Today's Date

_____

If under 18 years old, relationship to patient

Healthcare Laws Require Us To Have Written Consent In The Following Areas

Authorization to Release Information

***If I am accepted as a patient*,** I authorize this healthcare facility to release all information related to the care I receive, to my primary care physician, insurance company, third party payer, attorney, or their designee, as may be necessary for the coordination of care, payment of my bill, determining benefits, or for quality review.

Privacy and Confidentiality
I understand that this healthcare facility is making extensive effort to protect my personal privacy and information. I understand that there are some treatments and procedures that are not in a private setting such as, therapy tables and exercise rehabilitation. If I am uncomfortable with that setting, then I will notify the staff and they will try to accommodate me as much as possible. I also give permission for the office to leave messages regarding future appointments and information related to my care. Federal and State laws (HIPPA) requires all healthcare facilities to adhere to their policies regarding the release and disclosure of medical records. Records and x-rays are the property of this facility. Copies of records may be received only by authorization of the patient or guardian, request must be in writing and payment of those copies follow the usual/customary costs. 7-10 business days is required to process this request. I have received a copy of the privacy protection policy.

Authorization for Examination, Diagnostic Testing and Treatment

***If, after consultation and deemed appropriate*,** I authorize the performance of examination, laboratory, diagnostic tests, procedures and treatment deemed necessary by personnel in this office regarding my care. Necessary procedures will be discussed with the doctor on a case basis. I give the office staff permission to use their best clinical judgment regarding what is necessary to handle my case. I understand that occasionally it may be necessary for another doctor/therapist to treat me.

I understand that as with all medical procedures and treatments there are risks such as fracture, stroke, and the possibility that there will be no or little benefit for my particular condition. There is no guarantee of a cure. I understand that the doctor will explain the risk-benefits, prognosis of my condition and refer to another provider if needed. I understand that it may not be possible for every risk factor to be explained to me, I expect the doctor to use his best judgment in the management of my care. I also understand that the intent of this facility is to facilitate healthy body function primarily to musculoskeletal conditions and some individuals may need a medical provider to diagnosis and treat a certain disease. If medicines are prescribed, then risks will be explained. Medicines can only be administered by the medical doctor on staff.

Assignment of Benefits
I assign to Dr. Sunny R. Kim and all affiliates of Progressive Rehabilitation Medicine, P.C. all benefits payable to me for my care. If I ask this facility to handle my insurance claims for me, I authorize this healthcare facility be paid directly by the insurance company or other third party payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. Insurance company contracts are between the company and the insured individual(s).
Guarantee of Payment
I guarantee payment of all charges incurred for evaluation and treatment in accordance with the rates and terms of this healthcare facility. I understand that this agreement will start once I am accepted as a patient and my care plan and responsibilities are discussed.

Payment for all services is required on the same day and may be paid by, cash, check, VISA, Mastercard, Discover, or AMEX unless other arrangements have been made. If we are submitting claims for your insurance to pay, then your co-insurance and payment toward your annual deductible is also required at the time of service.

Payment plans and discounts are available; please ask if you are interested.
We are happy to file claims for you if appropriate. However, disputes regarding coverage, benefits, payments, etc. are strictly between the patient and the insurance company. Most insurance claims involve delay before we receive payment. Please keep in mind that we can't guarantee payment from the insurance company, your insurance is your responsibility and we may need your help to collect your claims for you. Ultimately, you are responsible for payment of any services.

I certify that I understand the above office policies and agree to abide by the same.

_____

Signature of patient or responsible party

_____
Today's Date

_____
If under 18 years old, relationship to patient