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.

_____

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

Patient Health Questionnaire (PHQ-9)

All new patient's please complete the following questionnaire to the best of your ability.

Patient Name: _____ Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the last 2 weeks, how often have you been bothered by any of the following problems:				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐