Advantage Physical Medicine and Rehabilitation, LLC

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OFFICE REGISTRATION

First Name: _____ MI: ___ Last Name: _____

Mailing Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ ext. _____ Cell Phone: _____

Email address: _____

Date of Birth: _____/_____/_____ Social Security #: _____ Circle: Male or Female

Primary Care Dr.: _____ Referring Dr.: _____

Pharmacy Name & Address: _____

Pharmacy Phone #: _____

Race (check one):

( ) White
( ) Black/African American
( ) American Indian/Alaska Native
( ) Native Hawaiian/Other Pacific Islander
( )Asian
( ) Other
( ) Patient declinded/Unknown

Ethnicity:

( ) Spanish/Hispanic Origin
( ) Not of Hispanic Origin

Primary Language: Country:

Secondary Language: Country:

Insurance Information Below:

Primary Insurance Company Name: _____

Address: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

ID #: _____ Relationship to Insured: Self, Spouse, Child, Other

Employer of policy holder: _____

Secondary Coverage: (If Applicable)

Insurance Company Name: _____ ID #: _____

Address: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

Symptom Checklist

NAME: **DATE:**

List Medical History (e.g., High blood pressure, cancer, etc)

List Surgeries :

Medications (with dosages) :

Drug Allergies:

Family History (medical problems in your immediate family)

Are you presently working? YES NO

What is your occupation? _____

If retired, what was your prior occupation? _____

Tobacco use: NO YES If YES, how much?

Alcohol use: NO YES If YES, how much?

Other drug use: NO YES If YES, what drug and how much?

Symptoms	**Please Circle**
Fever or night sweats	YES NO
Chest pain	YES NO
Loss of bowel control	YES NO
Loss of bladder control	YES NO
Inflammatory arthritis	YES NO
Skin rashes	YES NO
Weakness	YES NO
Depressed mood	YES NO
Difficulty sleeping	YES NO
Diabetes or thyroid disease	YES NO

NAME:
Date:

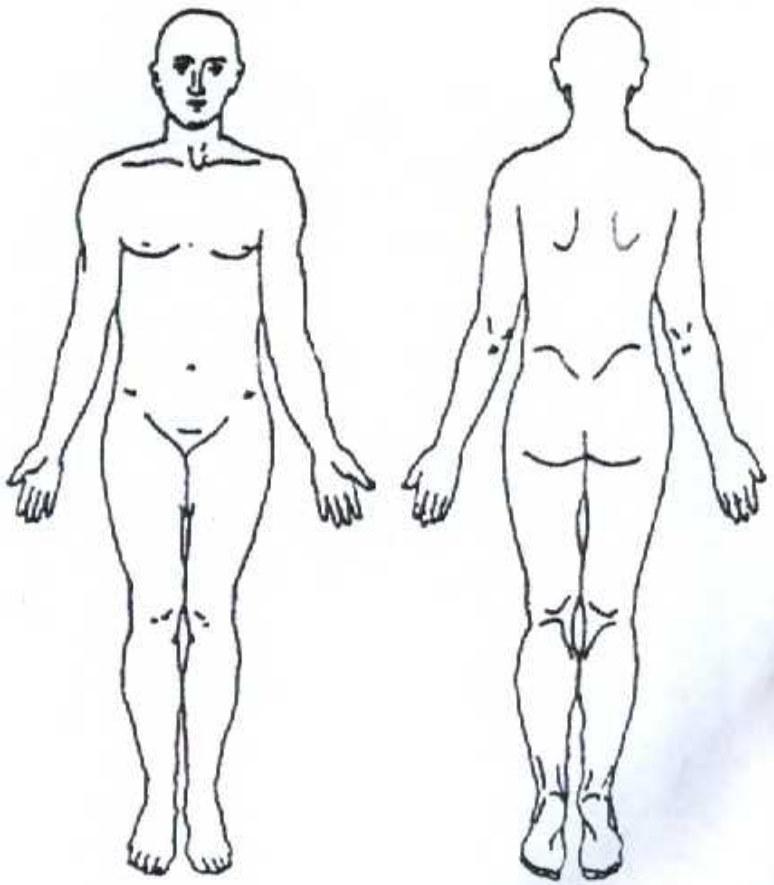
Where is your pain?
Where is your numbness/tingling?

Please mark on the diagrams:

Pain= X

Numbness/
Tingling= O

Both= ⊗



1. Was there an injury? If so, what is the date of injury?
2. How long have you had your pain?
3. Please describe the quality of your pain.
   (sharp, dull, stab, ache, throb or other)
4. Please rate your current pain level from 0 to 10.
5. Does your pain radiate or travel?
6. Is your pain constant or does it come-and-go?
7. What makes the pain worse?
   (bend, lift, sit, stand, walk or other)
8. What makes the pain better?
   (meds, rest, therapy, ice, heat or other)
9. Do you have any numbness or tingling?