Rehabilitation Physicians of Pittsburgh

New Patient Form

## OFFICE USE ONLY

| Date | H | W | BP | Pulse |
|---|---|---|---|---|
| | | | | |

## PATIENT INFORMATION

| Last Name | First Name | MI | Date of Birth | SSN |
|---|---|---|---|---|
| | | | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Please check preferred phone number | Cell Phone ☐ | Home Phone ☐ | Work Phone ☐ |
|---|---|---|---|

| Email Address | Marital Status |
|---|---|
| | ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other |

| Assigned Sex at Birth | Primary Language Spoken | Race (Optional) | Ethnicity (Optional) |
|---|---|---|---|
| ☐ F ☐ M | | | |

| Primary Care Physician | City | Phone |
|---|---|---|
| | | |

| Referring Physician | City | Phone |
|---|---|---|
| | | |

| Pharmacy | Address | Zip | Phone |
|---|---|---|---|
| | | | |

## EMERGENCY CONTACT

| Last Name | First Name | Phone | Relationship to Contact |
|---|---|---|---|
| | | | |

## PRIMARY INSURANCE

| Insurance Company | Copay (specialist) |
|---|---|
| | $ |

| Subscriber ID/Policy Number | Group Number |
|---|---|
| | |

| Subscriber (if policy is held by spouse/parent): | DOB |
|---|---|
| | |

## SECONDARY INSURANCE

| Insurance Company | Copay (specialist) |
|---|---|
| | $ |

| Subscriber ID/Policy Number | Group Number |
|---|---|
| | |

| Subscriber (if policy is held by spouse/parent): | DOB |
|---|---|
| | |

## LABOR & INDUSTRY/MOTOR VEHICLE ACCIDENT ONLY

Note: we do not bill 3rd party auto claims

| Is your claim active? ☐ No ☐ Yes | Claim Number | Policy Number | Date of Injury/accident |
|---|---|---|---|
| | | | |

| Insurance Carrier Name | Address | Name of Attorney |
|---|---|---|
| | | |

| Claims Manager Name | Phone Number | Fax Number |
|---|---|---|
| | | |

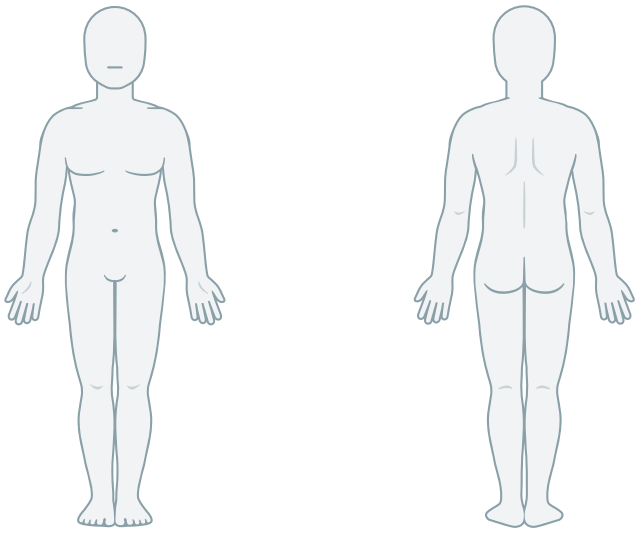
## REASON FOR VISIT

Please briefly describe the reason for today's visit

| Onset date of symptoms: _____ Duration of symptoms: _____ (days, weeks, months) | Describe your symptoms (check all that apply) ☐ Aching ☐ Burning ☐ Deep ☐ Dull ☐ Sharp ☐ Stabbing ☐ Superficial ☐ Throbbing ☐ Other_____ | Your symptoms are ☐ Occasional ☐ Frequent ☐ Constant ☐ Worsening ☐ Improving | Today, your level of discomfort/pain is ☐ No Pain ☐ Mild ☐ Moderate ☐ Severe | Did you stop working due to your pain? ☐ No ☐ Yes<br>Is one of your goals to return to work? ☐ No ☐ Yes<br>Is the pain tolerable? ☐ No ☐ Yes ☐ Sometimes |
|---|---|---|---|---|

## REASON FOR VISIT (CONTINUED)

Mark the areas on your body where you typically feel symptoms. Include all affected areas.



Indicate your current level of discomfort/pain below

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No pain — Worst pain ever

Associated Symptoms

- ☐ Balance Issues
- ☐ Bruising
- ☐ Buckling
- ☐ Catching/Locking
- ☐ Chills
- ☐ Drainage
- ☐ Fever
- ☐ Grinding
- ☐ Instability
- ☐ Loss In Bowel/Bladder
- ☐ Numbness
- ☐ Popping/Clicking
- ☐ Radiation Down Arm/Leg
- ☐ Redness
- ☐ Swelling
- ☐ Tingling
- ☐ Warmth
- ☐ Weakness
- ☐ Weight Loss

What makes your symptoms **BETTER?**

What makes your symptoms **WORSE?**

## MEDICAL HISTORY

☐ None of the below

Please check any conditions that apply to you, currently or past.

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding/Clotting Disorder
- ☐ Cancer
- ☐ COPD/Emphysema
- ☐ Coronary Atherosclerosis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ GERD/Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches/ Migraines
- ☐ Heart Attacks
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ HIV/AIDs
- ☐ Hypertension
- ☐ Insomnia
- ☐ Joint Infection
- ☐ Kidney Disease/Stones
- ☐ Leg or Foot Ulcers
- ☐ Lipid/Cholesterol
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Meningitis
- ☐ Mononucleosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Seizures/Epilepsy
- ☐ Sexually Transmitted Infection
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Tendonitis
- ☐ Thyroid Problems/Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Tract Infection
- ☐ Vision Loss

Other conditions not listed above:

## SURGICAL HISTORY

☐ I have not had any surgical procedures

Please list any surgical procedures you have had

| Surgery | Date (month/year) | Surgeon |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## CURRENT MEDICATIONS

☐ I do not take any medications

List all current medications including OTC's, Supplements, Vitamins, and Herbals

| Name of medication | Dosage/Frequency | Prescribing Physician |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## ALLERGIES

☐ No known allergies

List all known allergies (drugs, food, animals, etc.)

_____ _____

_____ _____

_____ _____

☐ IV contrast dye
☐ Latex
☐ Local anesthetics
☐ Shellfish
☐ None of the above

## FAMILY HISTORY

☐ Adopted

Please list all medical problems of your **immediate** family (such as diabetes, high blood pressure, heart disease, etc.) If deceased, please indicate cause of death.

_____ _____

_____ _____

_____ _____

## SOCIAL HISTORY

☐ Disability

| | | | |
|---|---|---|---|
| Occupation | | Current Employer | |
| Highest Level of Education | Marital Status | Do you have children? ☐ No ☐ Yes | How many? |

| | | |
|---|---|---|
| Nicotine Use ☐ Never | Frequency/Quantity | Type |
| Alcohol Use ☐ Never | Frequency/Quantity | Type |
| Recreational Drug Use ☐ Never | Frequency/Quantity | Type |
| Cannabis Use ☐ Never | Frequency/Quantity | How does cannabis help you? |

| | |
|---|---|
| Have you had any negative effects from cannabis? ☐ No ☐ Yes | If yes, please describe: |

| | | | | |
|---|---|---|---|---|
| What are you doing for exersice? | HOME SETUP | Number of Step to Enter | Number of Levels | 1st Floor Bed & Bath ☐ No ☐ Yes |

## REVIEW OF SYSTEMS

☐ None of the below

Check all symptoms that apply

- ☐ Abdominal pain
- ☐ Anxiety
- ☐ Balance problems
- ☐ Black stools
- ☐ Change in appetite
- ☐ Chest pain
- ☐ Chest palpitations
- ☐ Depressed mood
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Dizziness
- ☐ Double/blurry vision
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Fatigue
- ☐ Fevers
- ☐ Frequent nose bleeds
- ☐ General morning stiffness
- ☐ Headache
- ☐ Heartburn
- ☐ High blood pressure
- ☐ Increased thirst
- ☐ Jaundice
- ☐ Limb or joint swelling
- ☐ Loss in bowel/bladder
- ☐ Loss of hearing
- ☐ Nausea/vomiting
- ☐ Night pain
- ☐ Night sweats
- ☐ Numbness/tingling
- ☐ Shortness of breath
- ☐ Skin Rash/Psoriasis
- ☐ Sleep problems
- ☐ Unexplained cough
- ☐ Unintentional weight gain/loss
- ☐ Urinary frequency/ urgency
- ☐ Vision changes
- ☐ Wheezing

## ADDITIONAL INFORMATION

Is there anything else you would like us to know?

**By signing below I agree to the following:**

*The information supplied on this form is accurate and up-to-date to the best of my knowledge. I have reviewed a copy of the Rehabilitation Physicians of Pittsburgh financial policy and I agree to the terms and conditions. I allow the Rehabilitation Physicians of Pittsburgh to participate in the treatment of my health. I authorize the Rehabilitation Physicians of Pittsburgh to release information to my insurance company, my referring/consulting physicians or other healthcare providers as deemed appropriate*

*I hereby authorize my insurance benefits to be paid directly to the Rehabilitation Physicians of Pittsburgh and acknowledge the release of this information to my insurance company. I understand I am financially responsible for my co-pay, deductible/coinsurance and for non-covered services. I authorize my doctor to act as my agent in helping me obtain payment from the insurance. I agree that I will not withhold or delay payment if my insurance denies payment on any of my charges. I have been informed of the $35 fee on all return checks. In the event it should become necessary to involve a collections agency for unpaid balances, I agree that I will be responsible for unpaid balances, collection fees and interest. Should legal action be filed, I will accept financial responsibility for reasonable attorney fees, filing fees and any other accrued costs will be my responsibility. I attest that I have read the Notice of Privacy Practices which is posted in the reception area and also on the website (www.REHABPGH.com) and acknowledge that a hard copy of this is available to me at my request.*

*I am aware of the $25 charge for all late cancellations (less than 24 hours notice) and no show appointments. I am aware of the $50 charge for all no-show new patient and procedure appointments.*

*I permit a copy of this authorization to be used in place of the original.*

Patient/Responsible Party Signature

Date