INTEGRATED PHYSICAL MEDICINE

Integrated Physical Medicine
Integrated Rehab, Inc.
958 S. Kenmore Dr., Evansville, IN 47714
812-401-2140
www.ipmevansville.com

CONFIDENTIAL PATIENT INFORMATION SHEET

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Nickname _____

Birthday ____/____/____ Sex ☐ M ☐ F Race/Ethnicity _____

Preferred Language _____ E-Mail _____

Address _____ City/State _____ Zip _____

Soc. Sec. # _____ Home Phone _____ Cell _____

Marital Status: ☐ M ☐ D ☐ S ☐ W Children, Ages _____

Occupation _____ Employer _____

Work Phone _____

Who referred you to us? _____ How else did you hear about us? _____

Emergency Contact _____ Relationship to Patient _____

Emergency Contact Phone _____

INSURANCE INFORMATION

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

Insured's Name: _____ Relationship to patient: _____

Insured's SSN: _____ Insured's D.O.B.: _____

Insurance Company Name: _____

HISTORY OF PRESENT ILLNESS

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine Other _____

Other doctors or therapist who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years:

_____

_____

Do you have a family physician? Name _____

Medications, dosage and frequency:

_____

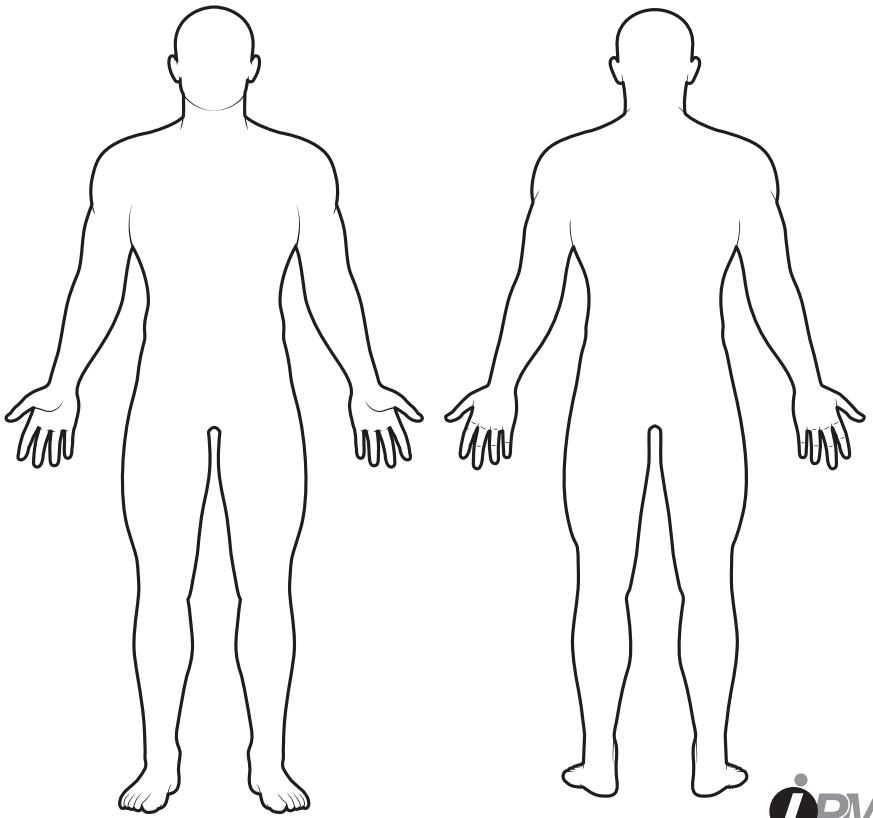
_____

Have you been in an auto accident or had any other personal injury? ☐ Y ☐ N Describe

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURES TO THE RIGHT.

Use following symbols:

8888 Aches
oooo Numbness
//// Stabbing
• • • • Pins/Needles



MARK AN "X" ON THE LINES:

How bad are your symptoms now?

_____
None Most Severe

How bad have they been in the past?

_____
None Most Severe

Name _____ Date _____

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

GENERAL	NOW	PAST
Weakness	☐ N	☐ P
Fatigue	☐ N	☐ P
Fever	☐ N	☐ P
Chills	☐ N	☐ P
Night Sweats	☐ N	☐ P
Fainting	☐ N	☐ P
SKIN		
Color Changes	☐ N	☐ P
Nail Changes	☐ N	☐ P
Hair Changes	☐ N	☐ P
Moles	☐ N	☐ P
Rashes	☐ N	☐ P
Sores	☐ N	☐ P
Weakness	☐ N	☐ P
HEAD		
Headaches	☐ N	☐ P
Injuries	☐ N	☐ P
Bumps	☐ N	☐ P
Last Eye Exam	_____	
Glasses	☐ N	☐ P
Contacts	☐ N	☐ P
Cataracts	☐ N	☐ P
EARS		
Hard of Hearing	☐ N	☐ P
Deafness	☐ N	☐ P
Ringing	☐ N	☐ P
Discharge	☐ N	☐ P
Earache	☐ N	☐ P
Itching	☐ N	☐ P
Dizziness	☐ N	☐ P
Room Spins	☐ N	☐ P
NOSE		
Decreased Smell	☐ N	☐ P
Bleeding	☐ N	☐ P
Pain	☐ N	☐ P
Discharge	☐ N	☐ P
Obstruction	☐ N	☐ P
Post Nasal Drip	☐ N	☐ P
Deviated Septum	☐ N	☐ P
Runny Nose	☐ N	☐ P
Sinus Congestion	☐ N	☐ P
MOUTH		
Bleeding Gums	☐ N	☐ P
Sores	☐ N	☐ P
Dental Problems	☐ N	☐ P
Bad Breath	☐ N	☐ P
Loss of Taste	☐ N	☐ P
Dry Mouth	☐ N	☐ P
Ulcers	☐ N	☐ P
Blisters	☐ N	☐ P

THROAT	NOW	PAST
Soreness	☐ N	☐ P
Bad Tonsils	☐ N	☐ P
Hoarseness	☐ N	☐ P
Pain	☐ N	☐ P
Trouble Swallowing	☐ N	☐ P
Recurrent Infections	☐ N	☐ P
NECK		
Neck Enlargement	☐ N	☐ P
Stiff Neck	☐ N	☐ P
Soreness	☐ N	☐ P
Lumps	☐ N	☐ P
Masses	☐ N	☐ P
BREASTS		
Discharge	☐ N	☐ P
Lumps	☐ N	☐ P
Pain	☐ N	☐ P
Bleeding	☐ N	☐ P
Nipple Changes	☐ N	☐ P
Skin Changes	☐ N	☐ P
Bloated	☐ N	☐ P
LUNGS		
Cough	☐ N	☐ P
Phlegm	☐ N	☐ P
Blood	☐ N	☐ P
Short of Breath	☐ N	☐ P
Wheezing	☐ N	☐ P
Pain	☐ N	☐ P
Congestion	☐ N	☐ P
Inhalant Exposure	☐ N	☐ P
HEART		
Murmur	☐ N	☐ P
Palpitations	☐ N	☐ P
Rapid Heartbeat	☐ N	☐ P
Swollen Extremities	☐ N	☐ P
Cold Extremities	☐ N	☐ P
Chest Pain/Pressure	☐ N	☐ P
Varicose Veins	☐ N	☐ P
Blood Clots	☐ N	☐ P
Blue Extremities	☐ N	☐ P
BLOOD		
Anemia	☐ N	☐ P
Low Blood Iron	☐ N	☐ P
Easy Bruising	☐ N	☐ P
Easy Bleeding	☐ N	☐ P
Swollen Nodes	☐ N	☐ P
Painful Nodes	☐ N	☐ P
Sugar in Blood	☐ N	☐ P
Red Spots	☐ N	☐ P

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐ N	☐ P
Nausea	☐ N	☐ P
Bloated	☐ N	☐ P
Belching	☐ N	☐ P
Heartburn	☐ N	☐ P
Indigestion	☐ N	☐ P
Irregular Bowel Habits	☐ N	☐ P
Constipation	☐ N	☐ P
Diarrhea	☐ N	☐ P
Gas	☐ N	☐ P
Hemorrhoids	☐ N	☐ P
Poor Appetite	☐ N	☐ P
Food Intolerance	☐ N	☐ P
Bloody Stools	☐ N	☐ P
Black Stools	☐ N	☐ P
GENITOURINARY		
Urgency	☐ N	☐ P
Incontinence	☐ N	☐ P
Straining	☐ N	☐ P
Back Pain	☐ N	☐ P
Frequent Voiding	☐ N	☐ P
Stones	☐ N	☐ P
Burning	☐ N	☐ P
Bed Wetting	☐ N	☐ P
Discharge	☐ N	☐ P
Dribbling	☐ N	☐ P
Cloudy Urine	☐ N	☐ P
Urine Color _____		
(MALE ONLY)		
Small Stream	☐ N	☐ P
Impotence	☐ N	☐ P
Last Prostate _____		
(FEMALE ONLY)		
Spotting Between Periods	☐ N	☐ P
Menstrual Cramps	☐ N	☐ P
Discharge	☐ N	☐ P
Itching	☐ N	☐ P
Painful Intercourse	☐ N	☐ P
Irregular Periods	☐ N	☐ P
Hot Flashes	☐ N	☐ P

Contraception Type _____
Age at First Period _____
Duration of Cycle _____
Duration of Flow _____
No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Abortions _____
Menstrual Flow ☐ Heavy ☐ Mod ☐ Light
Last Period _____
Last Pap Smear _____
Last Vaginal Exam _____
Last Mammogram _____

Name _____ Date _____

NEUROLOGIC	NOW	PAST
Seizures	☐ N	☐ P
Vertigo	☐ N	☐ P
Dizziness	☐ N	☐ P
Hand Trembling	☐ N	☐ P
Loss of Sensation	☐ N	☐ P
Incoordination	☐ N	☐ P
Loss of Facial	☐ N	☐ P
Weak Grip	☐ N	☐ P
Paralysis	☐ N	☐ P
Difficulty Speech	☐ N	☐ P
Tingling	☐ N	☐ P
Loss of Memory	☐ N	☐ P
Numbness	☐ N	☐ P

ENDOCRINE

Weight Loss	☐ N	☐ P
Weight Gain	☐ N	☐ P
Extremely Thin	☐ N	☐ P
Heat Intolerance	☐ N	☐ P
Cold Intolerance	☐ N	☐ P
Hair Changes	☐ N	☐ P
Breast Changes	☐ N	☐ P

IMMUNIZATION/VACCINATION

DPT	Y ☐
Mumps	Y ☐
Smallpox	Y ☐
Typhoid	Y ☐
Tetanus	Y ☐
Measles	Y ☐
Pneumococcal	Y ☐
Influenza	Y ☐
Polio	Y ☐
MMR	Y ☐

BLOOD TYPE

A + ☐ A - ☐
B + ☐ B - ☐
AB + ☐ AB - ☐
O + ☐ O - ☐
Other _____

BLOOD TRANSFUSIONS

Date_____
Date_____
Date_____
Date_____

PSYCHIATRIC	NOW	PAST
Hyperventilation	☐ N	☐ P
Insecurity	☐ N	☐ P
Depression	☐ N	☐ P
Troubled Sleep	☐ N	☐ P
Irritable	☐ N	☐ P
Undecidedness	☐ N	☐ P
Timid	☐ N	☐ P
Hallucinations	☐ N	☐ P
Loss of Memory	☐ N	☐ P
Alcoholism	☐ N	☐ P
Drug Addiction	☐ N	☐ P
Drug Dependent	☐ N	☐ P
Suicidal Thoughts	☐ N	☐ P
Extreme Worry	☐ N	☐ P
Sexual Problems	☐ N	☐ P

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	☐ N	☐ P
Muscle Weakness	☐ N	☐ P
Muscle Cramps	☐ N	☐ P
Muscle Twitching	☐ N	☐ P
Joint Stiffness	☐ N	☐ P
Joint Pain	☐ N	☐ P

PAST MEDICAL HISTORY. Check only the ones you have had in the past .

Hay Fever	Y ☐	Parasites	Y ☐
Mumps	Y ☐	Epilepsy	Y ☐
Rheumatic Fever	Y ☐	Paralysis	Y ☐
Allergies	Y ☐	Polio	Y ☐
Angina	Y ☐	Mental Illness	Y ☐
Cancer	Y ☐	Alcoholism	Y ☐
Tumor	Y ☐	Depression	Y ☐
Blood Disease	Y ☐	Nervous Breakdown	Y ☐
Leukemia	Y ☐	Migraine	Y ☐
Heart Trouble	Y ☐	Gout	Y ☐
Varicose Veins	Y ☐	Hemorrhoids	Y ☐
Phlebitis	Y ☐	Prostate Problems	Y ☐
Hypertension	Y ☐	Sexual Problems	Y ☐
Stroke	Y ☐	Gonorrhea	Y ☐
Ulcers	Y ☐	Syphilis	Y ☐
Jaundice	Y ☐	Diabetes	Y ☐
Skin Trouble	Y ☐	Bladder Trouble	Y ☐
Gallstones	Y ☐	Kidney Stones	Y ☐
Liver Trouble	Y ☐	Kidney Infections	Y ☐
Hepatitis	Y ☐	Dysentery	Y ☐

Date of Last Chest X-Ray _____ ☐ Normal ☐ Abnormal ☐ N/A

Last TB Skin Test _____ ☐ Normal ☐ Abnormal ☐ N/A

Allergies: _____
_____
_____
_____
_____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight?_____ Height _____

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week _____ Type _____

Smoking ☐ Current ☐ Previous Packs/Day _____ No. of years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine *(Coffee, Tea, Cola)* Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____ Others _____

Name _____ Date _____

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OFFICE POLICIES

Patient: _____ Date of Birth: ____-____-_____

Thank you for choosing us as your health care provider!

Financial Policy & Federal Truth-in-Lending Statement: IPM proudly serves as a "preferred-provider" for virtually every insurance carrier, but all fees associated with rendered procedures are ultimately the patient's responsibility. Your co-payments as well as the estimated deductible and/or coinsurance portions of your bill must be paid at the time of service unless an authorized payment plan is in place. IPM accepts cash, check ($40 returned check fee), all major credit cards and Pay. If we should receive payments in excess of the estimated fees, any balance owed to you will be paid via check within 30 days. Any balance 60 days old or older from the date of service will incur a monthly 2.0% finance charge. In the event your account becomes more than 30 days past due, you agree to pay all costs of collection, including but not limited to collection agency fees, reasonable attorney fees, or IPM's collection agency's reasonable attorney fees and/or court costs. You authorize the release of financially identifiable information concerning your account to IPM's attorney and/or collection agency and/or the collection agency's attorney should collection procedures as described become necessary.

I understand and agree with the above **Financial Policy**. Initials _____

Appointment Cancellation Policy: We understand that "life happens"; we hope you understand that appointments are in high demand, and your early cancellation will allow another patient, one likely in pain, access to care. To this end, we require that you cancel your appointment with us by 3:00 p.m. on the day before the appointment. If your appointment is on Monday, the cut-off time is 3:00 p.m. on Friday. If for any reason you do not provide us this notice, you agree to pay a $25 fee for each missed appointment. You may have multiple appointments on the same day (e.g., Massage Therapy and Chiropractic). Each of these appointments is counted individually with regards to this policy.

I understand and agree with the above **Appointment Cancellation Policy**. Initials _____

IPM Patient Portal: For those who want secure, anytime access to their personal health records maintained by our office, we offer the IPM Patient Portal. This innovative system enables our patients to send staff members messages, request appointments and review their electronic health records – all with secure access wherever Internet service is available.

Please select one of the following:
☐ I do not wish to have my IPM Patient Portal account login information
☐ I would like to have my IPM Patient Portal account login information

Patient's or Legal Guardian's Signature: _____ Date: _____

Printed Name of Responsible Party if someone other than Patient: _____

Relationship to Patient: ☐Self ☐Parent ☐Spouse ☐Other: _____

INTEGRATED PHYSICAL MEDICINE

PATIENT CONSENT FOR RELEASE OF INFORMATION

By signing this form, you are granting consent to Integrated Rehab, Inc. DBA: Integrated Physical Medicine to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 812-401-2140. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE CONSENT TO RELEASE INFORMATION

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is corret. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claims.

_____
Print Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Print Name of Legal Representative Relationship of Legal Representative to Patient (if applicable)

_____
Signature of Legal Representative