Apple Physical Medicine and Rehabilitation
7446 Shallowford Road Suite 108 Chattanooga TN, 37421
Phone (423)855-7376 Fax (423)855-7376
Email info@applerehabgroup.com Website applerehabgroup.com

Patient Information

*Please **PRINT** in pen legibly and fill out completely*

Name: ______________________________ Date: ______________________

Address: ______________________ City: ______________ State: _____ ZIP: ________

Email Address: ________________________ Social Security Number: ______________

Birth Date: ___________ Driver's License Number: _______________ License State: _______

Preferred Mode of Contact: ☐ Phone ☐ Text ☐ Email ☐ **Preferred Language:** ☐ English ☐ Spanish ☐
Race: ☐ White ☐ Hispanic ☐ Non- Hispanic ☐ African American ☐ Native American ☐ Other ____________

Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Living Alone** ☐ **Living with Others**

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Employer: ______________________________Occupation: ______________________

Emergency Contact: ____________________ Relation: ______________ Phone: _______________

Family Physician: ___________________________ Phone: ______________________

How did you hear about our office: ☐ **Friend** ☐ **Radio** ☐ **TV** ☐ **Internet** ☐ **Insurance Company**
Other: ____________________

If referred by physician please provide name: ____

Please Allow Our Office
To Make A Copy Of Your Insurance Card/s And License

AUTHORIZATION FOR TREATMENT, RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS

I hereby authorize Apple Physical Medicine and Rehabilitation and Staff to administer such treatments and release information regarding treatment or examination rendered to me for medical care to insurance company(s) or its representatives. I also authorize payment to be made directly to Apple Physical Medicine and Rehabilitation the amount due for all provided services for my eligible dependents or myself. I understand that I am financially responsible for any amounts not covered or paid by my insurance company. **Furthermore, I authorize Apple Physical Medicine and Rehabilitation to obtain my medical records from any necessary doctor's office hospital, or clinic.**

Name: ____ Date: ____________

Signature of Patient or Guardian: ______________________________ Date: ____________

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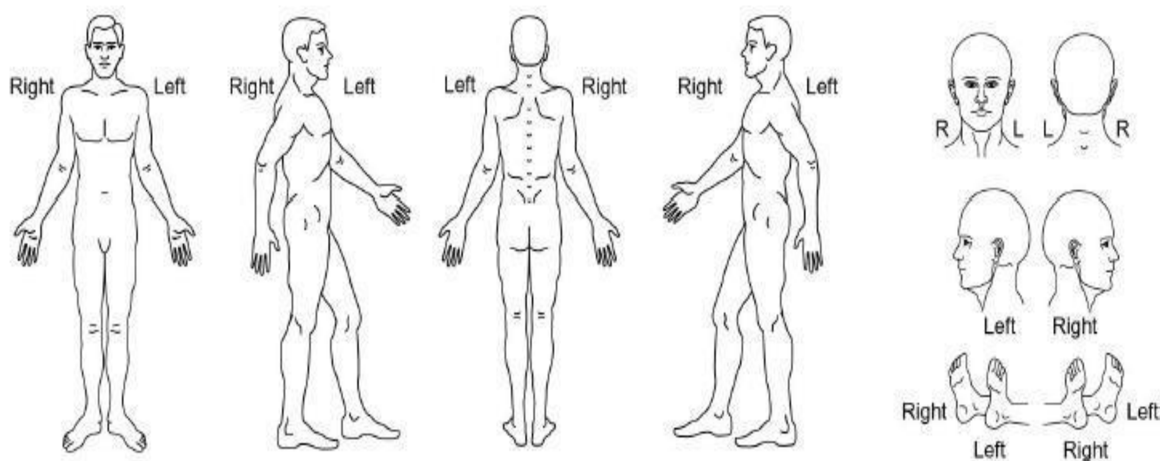
Pain History:

Chief Complaint (Reason for your visit today)? ____________________________

Does this pain radiate? If so where? ____________________________

Please list any additional areas of pain: ____________________________

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset Of Symptoms:

Approximately, when did this pain begin? ____________________________

What caused your current pain episode? ____________________________

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description:

Describe the character of your pain: ☐Dull ☐Aching ☐ Sharp ☐Stabbing, ☐Throbbing ☐ Tingling

What time of day is your pain at its worst? ☐Morning ☐Afternoon ☐Evening

How often does the pain occur? ☐ Constant ☐Changes in severity but always-present ☐ Intermittent (comes and goes)

Pain Description Continued:

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now _____The Best It Gets _____The Worst It Gets _____

What other factors worsen or affect your pain? ____

____

What other factors relieve your pain? ____

____

Are there any associated symptoms? (e.g.: numbness/tingling/weakness/incontinence, etc.) ______________

____

What are the goals you wish to achieve with Treatment? ____

____

Diagnostic Tests and Imagining:

☐MRI of the: ____ Date: ______________

☐X-Ray of the: ____Date: ______________

☐CT Scan of the: ____Date: ______________

☐EMG/NCV study of the: ______________________________________Date: ______________

☐Other Diagnostic Testing: ____________________________________Date: ______________

☐ *I have not had ANY diagnostic tests for my current pain complaint*

Please List The Following Treatment You Have Tried and Check (B) Better (W) Worse (N) No Change:

☐Spine Surgery ☐B ☐ W ☐N ☐Physical Therapy ☐B ☐ W ☐N ☐Chiropractic Care ☐B☐ W☐N

☐Psychological Therapy ☐B ☐ W ☐N ☐Brace Support ☐B ☐ W ☐N ☐Acupuncture ☐B ☐ W ☐N

☐Hot/Cold Packs ☐B ☐ W ☐N ☐Massage Therapy ☐B ☐ W ☐N ☐TENS Unit ☐B ☐ W ☐N

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) Where ____

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ Nerve Blocks – Area/Nerve(s) - ____

☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant______________________________

☐ Trigger Point Injections – Where? ____

☐ Vertebroplasty/Kyphoplasty – Level(s) ____

☐ Other____

Which of these procedures listed above have helped with your pain? ___________________

____

Mark the following physicians or specialists you have consulted for your current pain problem(s)

☐Acupuncturist ☐Chiropractor ☐Internist ☐Neurosurgeon ☐Orthopedic Surgeon

☐Physical Therapist ☐Psychiatrist/Psychologist ☐Rheumatologist ☐Neurologist

Surgical History

Please list any surgical procedures you have had done in the past including date:

1) ____ Date: ___________

2) ____ Date: ___________

3) ____ Date: ___________

4) ____ Date: ___________

5) ____ Date: ___________

☐ *I have NEVER had any surgical procedures performed.*

Family History

Mark all appropriate diagnoses as they pertain to your parents and siblings:

☐Arthritis ☐Headaches/Migraines ☐Liver Problems ☐Seizures ☐Cancer ☐ High Blood Pressure

☐ Osteoporosis ☐Diabetes ☐Stroke ☐Kidney disease ☐Rheumatoid Arthritis

☐Other Medical Problems: ____

☐ *I have no significant family medical history*

Social History

Occupation: ____

☐Retired ☐Unemployed ☐Temporary Disability ☐Permanent Disability

☐Are you currently under worker's compensation? ☐Yes ☐No

☐ Is there an ongoing lawsuit related to your visit today? ☐Yes ☐No

Tobacco Use: ☐Current user ☐Former user ☐Never used ☐Packs per day? ____☐How many years? _____

Alcohol Use: ☐Never ☐Social ☐Daily ☐History Of Alcoholism ☐Current Of Alcoholism

Illegal Drug Use: ☐Denies any illegal drug use ☐Currently uses illegal drugs ☐ Formerly used illegal drugs (not currently)

Have you ever-abused narcotic or prescription medications? ☐Yes ☐No

Current Medications:

****Are you currently taking any blood thinners or anti-coagulants?** ☐YES ☐No

If YES, which ones? ☐Aspirin ☐Plavix ☐Coumadin ☐Lovenox ☐Other _______________

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:
Medication Name

1) ____ 2) ____

3) ____ 4) ____

5) ____ 6) ____

7) ____ 8) ____

9) ____ 10) ______________________________________

Allergies ☐ No Know Allergies

Do you have any drug/medication allergies? Please list all medications you are allergic to

Medication Name

1) ______________________________ 2) ______________________________

3) ______________________________ 4) ______________________________

5) ______________________________ 6) ______________________________

******Topical Allergies: ☐Latex ☐Yes ☐No ☐IV Contrast ☐Yes ☐No**

******Do You Have Allergies To Birds, Feathers, Eggs or Products Containing Shellfish? ☐Yes ☐No**

******Iodine? ☐Yes ☐No**

Review of Symptoms

Mark the following symptoms that you currently suffer from:

Constitutional: ☐Fevers ☐Chills ☐Sweats ☐Weakness ☐Fatigue ☐Decreased Activity

☐Unexplained weight gain ☐Unexplained weight loss ☐Difficulty sleeping

Eyes: ☐Blurriness ☐Double vision ☐Visual disturbance ☐Pain

Ears/Nose/Throat/Neck: ☐Hearing problems ☐Ear pain ☐Sinus problems ☐Sore throat ☐Nosebleeds

Respiratory: ☐Shortness of breath ☐Cough ☐Sputum production ☐Wheezing

Cardiovascular: ****☐Blood clots** ☐Chest pain ☐Palpitations ☐Swelling in feet ☐Shortness of breath during sleep ☐Bleeding disorder ☐Fainting

Gastrointestinal: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Heartburn ☐Abdominal pain

Genitourinary/Nephrology: ☐Painful urination ☐Blood in urine ☐Change in urine stream ☐Unusual discharge ☐Flank pain ☐Urinary incontinence

Musculoskeletal: ☐Back pain ☐Neck pain ☐Joint pain ☐Muscle pain ☐Muscle cramp ☐ Muscle spasm ☐Gait disturbances ☐Joint stiffness ☐Joint swelling ☐Trauma

Integumentary: ☐Rash ☐Itching ☐Lesions ☐Bruising

Neurological: ☐Abnormal balance ☐Confusion ☐Numbness ☐Tingling ☐Dizziness ☐Headaches

☐Loss of coordination ☐Memory loss ☐Seizures ☐Tinnitus ☐Tremors ☐Vertigo

Psychiatric: ☐Feeling anxious ☐Depressed mood ☐Stress problems ☐Suicidal Thoughts