Apple Rehab Group
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Phone: 423-855-7376 Fax: 423-855-8455
Website: applerehabgroup.com

Patient Information

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

Name: _____ **Date**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Email: _____ **Social Security Number**: _____

Birth Date: _____ **Gender**: ☐ Male ☐ Female ☐ Other _____

Preferred Mode of Contact: ☐ Phone ☐ Text ☐ Email. **Ethnicity**: ☐ Hispanic/ Latino ☐ Non-Hispanic/ Latino

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ **Race**: ☐ White ☐Black ☐Asian ☐American Indian

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Widowed ☐ Living with others

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Employer: _____ **Occupation**: _____

Emergency Contact: _____ **Relation**: _____ **Phone**: _____

Family Physician: _____ **Phone**: _____

Preferred Pharmacy: _____ **Phone**: _____

How did you hear about our office? ☐ Friend ☐ Radio ☐ TV ☐ Internet ☐ Insurance

If referred by a physician, please provide name: _____

Please allow out office to make a copy of your insurance card/s and license.

AUTHORIZATION FOR THE TREATMENT, RELEASE OF MEDICAL INFORMATION, AND ASSIGNMENT OF BENEFITS.

I hereby authorize Apple Rehab Group to administer such treatments and release information regarding the 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 Rehab Group in 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 Rehab Group to obtain my medical records from any necessary hospital, clinic, or doctor's office.

Name: _____ Signature: _____ Date: _____

Patient Questionnaire

Chief Complaint Location/Problem(Reason for today's visit):

_____

_____

Did the problem result from a specific injury? ☐ Yes ☐ No **Injury/Accident Date**: _____

If you answered yes, please explain:

_____

If your condition is not due to a recent accident or injury, how long have you had this condition?

_____

How did your problem start? **Details** :

_____

_____

_____

Is the pain: ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

Is the pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Numb ☐ Tight ☐ Tingling ☐ Burning

Please rate your pain on a sale from 1-10 (10 Being the most painful)
At its worst: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
At rest: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Are you experiencing any of the following: ☐ Locking ☐ Catching ☐ Popping ☐ Grinding

What makes the symptoms better? ☐ Rest ☐ Ice ☐ Heat ☐ Walking ☐ Standing ☐ Stretching ☐ Exercise ☐ Adjustments ☐ Twisting ☐ Medication ☐ Bending ☐ Working overhead ☐ Lifting ☐ Turning Neck ☐ Movement ☐ Looking up/down ☐ Massage ☐ Other _____

What makes the symptoms worse? ☐ Rest ☐ Ice ☐ Heat ☐ Walking ☐ Standing ☐ Stretching ☐ Exercise ☐ Adjustments ☐ Twisting ☐ Medication ☐ Bending ☐ Working overhead ☐ Lifting ☐ Turning Neck ☐ Movement ☐ Looking up/down ☐ Massage ☐ Other _____

What treatments have you tried? ☐ Nothing ☐ Rest ☐ Ice ☐ Heat ☐ Exercise ☐ Chiropractic ☐ Physical Therapy ☐ Bracing ☐ Medication ☐ Epidural Injections Massage ☐ Acupuncture

Have you had any of the following tests?
☐ Xray ☐ MRI ☐ Cat Scan ☐ NCV/EMG What Facility? _____

Current Medications: ☐ Not taking any medications or vitamins

Medications: Please list all medications including prescriptions, over the counter, vitamins, minerals, and herbs

Medication	**Dose**	**Frequency**

Allergies-
Are you allergic to any medications? ☐ Yes ☐ No ☐ No known allergies?
***** Topical Allergies**: ☐ Latex ☐ IV Contrast ☐ Birds ☐ Feathers ☐ Eggs ☐ Shellfish ☐ Iodine
If yes what is the reaction: ☐ Rash ☐ Anaphylactic ☐ Mild ☐ Moderate ☐ Severe
If yes please list all medications/ foods you are allergic to:

_____
_____

Social History

Tobacco Use: ☐ Yes ☐ No ☐ Chewing tobacco ☐ Vape ☐ Former
Alcohol Use: ☐ Yes ☐ No Frequency: _____
Caffeine Use: ☐ Yes ☐ No Frequency: _____
Recreational Drug Use: ☐ Yes ☐ No Type and Frequency: _____
Have you ever abused narcotic or prescription drugs? ☐ Yes ☐ No

Surgical History ☐ Never had any surgical procedures
Please list any surgical procedures that you have had done in the past including dates:

1._____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Family History

Mother: ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Seizures ☐ Headaches
Father: ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Seizures ☐ Headaches
Maternal Grandparents: ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Seizures ☐ Headaches
Paternal Grandparents: ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Seizures ☐ Headaches

Review of systems

General: ☐ Fever ☐ Sweats ☐ Chills ☐ Fatigue ☐ Sleep Disturbance

Musculoskeletal: ☐ Neck Pain ☐ Back Pain ☐ Joint Pain ☐ Muscle Pain ☐ Muscle Cramp ☐ Muscle Spasm ☐ Joint Stiffness ☐ Swelling in Joints ☐ Jaw Pain ☐ Arthritis ☐ Fractures ☐ Dislocation

Neurological: ☐ Headaches ☐ Seizures ☐ Numbness ☐ Tingling ☐ Tremors ☐ Stroke ☐ Dizziness ☐ Fainting ☐ Abnormal balance ☐ Vertigo ☐ Head Trauma ☐ Blacking out ☐ Epilepsy ☐ Difficulty Walking

EENT: ☐ Glaucoma ☐ Cataracts ☐ Glasses/contacts ☐ Changes in Vision ☐ Blurry Vision ☐ Double Vision ☐ Sensitive to Light ☐ Ringing in Ears ☐ Frequent infections ☐ Earache ☐ Hearing loss ☐ Nasal Discharge ☐ Nasal Congestion ☐ Nose Bleeds ☐ Sinus Pain/ Pressure ☐ Sore Throat ☐

Mouth: ☐ Cold Sores ☐ Trouble Swallowing ☐ Changes in Taste ☐ Swelling

Respiratory: ☐ Asthma ☐ Shortness of Breath ☐ Cough ☐ Wheezing ☐ Difficulty Breathing ☐ Pneumonia ☐ Coughing up blood ☐ Tuberculosis

Vascular/ Cardiovascular: ☐ Anemia ☐ Chest Pain ☐ Palpitation ☐ heart disease ☐ Hypertension ☐ High Cholesterol ☐ Blood Clots ☐ Bleeding Disorder ☐ Heart Murmur ☐ Ankle Swelling ☐ Cold Hands/Feet ☐ Leg Cramps ☐ Calf Pain ☐ Varicose Veins ☐ Low Blood Pressure

Gastrointestinal: ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain ☐ Heartburn ☐ Change in Appetite ☐ Nausea/ Vomiting ☐ Gastritis/ Ulcer Disease ☐ GERD (Acid Reflux) ☐ Blood in Stool ☐ Hemorrhoids ☐ Gall Bladder Disease ☐ Liver Disease

Genitourinary: ☐ Trouble Urinating ☐ Pain with Urination ☐ Blood in Urine ☐ STD ☐ HIV/Aids ☐ Unusual Discharge ☐ Flank Pain ☐ Incontinence ☐ Urinary Infection ☐ Kidney Stones

Endocrine: ☐ Excessive Weight Gain/ Loss ☐ Excessive Thirst/ Hunger ☐ Hot/Cold Intolerance ☐ Diabetes ☐ Thyroid Disease ☐ Hepatitis

Integumentary: ☐ Rash ☐ Itching ☐ Lesions ☐ Bruising ☐ Eczema ☐ Hair Loss ☐ Warts ☐ Changes in Moles

Psychiatric: ☐ Feeling Anxious ☐ Depressed Mood ☐ Stress Problems ☐ Suicidal Thoughts ☐ Mood Swings

We have permission to (please check all that apply):

- ☐ Leave messages on home phone or with household members
- ☐ Leave messages on work phone
- ☐ Leave messages on cell phone
- ☐ Confirm appointments by phone or text
- ☐ Send emails

This authorization is effective though (please check one)

- ☐ ___/_____/_____
- ☐ No **EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative.

I understand That I may revoke this authorization to disclose information at any time by notifying our office in writing (Termination of Disclosure Form provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by this office until the termination request is received in writing and processed.

HIPPA

Release of Personal Information to Non-Medical Persons

I allow the individuals listed below to have access to the following information contained in my records. (Circle all that apply): MEDICAL – FINANCIAL – BOTH. You may revoke this authorization at any time in writing.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

☐ None

Patient Signature: _____ Date: _____

Know your Rights Please Review our HIPPA Policies

Our HIPPA policies are available posted in our office and on our website. If you would like a copy, please feel free to ask a staff member.
By signing this agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices

Patient Name: _____ Signature: _____ Date: _____

Limited Prescribing Agreement

We would like all our patients to understand that we will not under any circumstances be prescribing narcotics. Due to the high occurrence for addition/tolerance, we choose not to engage in this type of prescribing. We will however attempt to find non-narcotic ways to relieve any pain that you may be experiencing. We appreciate your cooperation with this agreement by not asking or expecting to receive any type of narcotic pain medication. Please sign below that you understand and will cooperate with this agreement.

Print Name: _____ Date: _____

Patient Signature _____

Staff Signature: _____ Date: _____

CONTROLLED SUBSTANCE AGREEMENT MUST BE SIGNED PRIOR TO ANY CONTROLLED SUBSTANCE PRESCRIPTION.

CONTROLLED SUBSTANCE AGREEMENT

This Controlled Substance Agreement (“Agreement”) is entered into between the prescribing healthcare provider, hereinafter referred to as the “Provider”, and the Patient, hereinafter

referred to as the “Patient”, for the purpose of establishing guidelines, responsibilities, and expectations regarding the use and management of controlled substances. Both the Provider and the Patient agree to the following:

1. Purpose and Scope: a. The Provider agrees to prescribe controlled substances, NOT INCLUDING NARCOTICS, to the Patient only for legitimate medical purposes in accordance with applicable laws and regulations. b. The Patient agrees to use the prescribed controlled substances solely to treat the medical condition(s) for which they are prescribed.
2. Compliance with Laws: a. The Provider shall comply with all federal, state, and local laws, regulations, and guidelines pertaining to the prescribing, dispensing, and documentation of controlled substances. b. The Patient shall comply with all federal, state, and local laws, regulations, and guidelines pertaining to controlled substance possession, use, and storage.
3. Informed Consent: a. The Patient acknowledges that the Provider has informed them of the risks, benefits, and alternatives of using controlled substances for the treatment of their medical condition(s). b. The Patient consents to the Provider’s collections, use, and disclosure of their medical information as necessary to manage controlled substances safely and effectively.
4. Treatment Plan and Monitoring: a. The Provider shall establish a treatment plan for the Patient, including using controlled substances. b. The Patient agrees to follow the treatment plan as prescribed by the Provider and to promptly report any concerns, side effects, or changes in their condition. c. The Provider reserves the right to modify or discontinue the use of controlled substances if it is determined to be medically necessary or if the Patient fails to comply with the treatment plan.
5. Prescription Refills and Early Refills: a. The Provider shall prescribe controlled substances by following laws and regulations, including limitations on the quantity and duration of the prescriptions. b. The Patient agrees to follow the prescribed dosages, intervals, and instructions for the controlled substance use and to request refills in a timely manner to avoid any interruptions in treatment. c. The Patient understands that early refills of controlled substances may not be granted except under exceptional circumstances determined by the Provider.
6. Controlled Substance Monitoring: a. The Provider may utilize various monitoring measures, such as urine drug screens, pill counts, or prescription monitoring programs, to ensure the appropriate use of controlled substances. b. The Patient agrees to cooperate with any monitoring measures deemed necessary by the Provider, including providing urine samples, returning unused medications, and providing access to their prescription history.
7. Medication Security and Storage: a. The Patient shall store controlled substances in a secure and locked location, out of the reach of children and unauthorized individuals. b. The Patient shall promptly report and loss, theft, or unauthorized use of controlled substances to the Provider.

8. Non-Transferability of Prescriptions: a. The Patient acknowledges that prescriptions for controlled substances are non-transferrable and shall not transfer or sell their medication to others. b. The Patient understands that sharing or selling controlled substances is illegal and may result in legal consequences.
9. Termination of Agreement: a. Either party may terminate this Agreement at any time by providing written notice to the other party. b. The Provider may terminate this Agreement immediately if there is a breach of any terms outlined herein or if the Provider determines, in their professional judgement, that it is no longer appropriate to prescribe controlled substances to the Patient.
10. Agreement Review and Amendments: a. This Agreement shall be review periodically.

Name (Print): _____ Date: _____

Signature: _____

Witness Signature: _____ Date: _____