Celebrating 50 years 2017 Rehabilitation Physicians, PC

PATIENT INFORMATION FORM FOR ESTABLISHED PATIENTS (Rechecks)
(PLEASE COMPLETE EVERYTHING ABOVE THE DOTTED LINE, AND ONLY THOSE AREAS THAT HAVE CHANGED BELOW THE DOTTED LINE)

Date: _____ Name: _____ DOB: _____ Age: _____ Occupation: _____

Current Problem(s): _____

_____

_____

Severity (Normal = 0 - - - - - > Excessive = 10) _____

Are you better? Yes ❑ % Better _____; Same? Yes ❑ ; Worse? Yes ❑ % Worse _____; Is there night pain? Yes ❑ No ❑

What makes the symptoms better? _____

_____

Worse? _____

_____

Other Associated Symptoms? _____

_____

. . . . . .

What **NEW TREATMENT** and/or **MEDICATIONS** are you using now? _____

_____

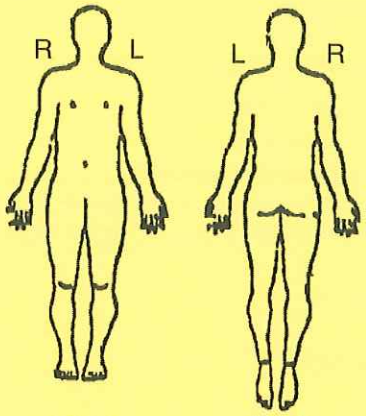
_____

_____

What **OTHER TESTS** have you had? _____

_____

Where is your Pain?



Aching = ^^^^^^ Burning = -------

Stabbing = /////// Numbness/Tingling = oooooo

(CHANGES FROM PREVIOUS VISIT)

PAST HISTORY: (Accidents, Illnesses, Surgeries) _____

_____

Allergies to Medications: _____

OTHER PROBLEMS: Review of Systems

	Yes	No		Yes	No		Yes	No
Head	❑	❑	Bladder	❑	❑	Psychiatric	❑	❑
Throat	❑	❑	Bowel	❑	❑	Weight Gain	❑	❑
Chest	❑	❑	Fever/Chills	❑	❑	Weight Loss	❑	❑
Heart	❑	❑	Muscles	❑	❑	Appetite	❑	❑
Abdomen	❑	❑	Bones	❑	❑	Blood	❑	❑
			Skin	❑	❑	Endocrine Glands	❑	❑

SOCIAL HISTORY: Are you performing your own housework? YES ❑ NO ❑

Are you working now? YES ❑ NO ❑ If NO, Last Day Worked: _____

Full Duty ❑ Limited Duty ❑ Explain: _____

Are you participating in sports? YES ❑ NO ❑

OTHER: _____

_____

FOR FEMALES ONLY: COULD YOU BE PREGNANT? Yes ❑ No ❑ ARE YOU BREAST FEEDING? Yes ❑ No ❑

_____ Physician Signature

_____ Patient Signature

(Do not write below this line)

Notes:
Height: _____ Weight: _____ Change from last visit: _____ BP: _____ Pulse: _____

PHYSICAL EXAMINATION: ** Can use N for Normal

1) NAME _____ DATE _____

RESP _____ HGT _____ WT _____ B/P _____ PULSE _____ TEMP _____

2) APPEARANCE _____

GAIT _____

Inspection/Palpation Range-of-Motion Stability Strength and Tone

3-6) NECK _____

& BACK _____

RUE _____

LUE _____

RLE _____

LLE _____

7) SKIN: NECK _____ BACK _____ RUE _____ LUE _____ RLE _____ LLE _____

8) COORDINATION

9) REFLEXES

10) SENSATION

11) MENTAL STATUS

12) MOOD AFFECT

LANGUAGE

KNOWLEDGE/MEMORY

13) PERIPH. PULSES, VARICOSITIES, EDEMA, ETC.

14) LYMPH NODES, AXILLA, NECK AND/OR GROIN

TEST RESULTS:

OTHER REPORTS:

DIAGNOSES:

PLAN:

RISK OF COMPLICATIONS/SEVERITY:

INSTRUCTION/COUNSELING:

GOALS:

PROGNOSIS:

OTHER/PATIENT QUESTIONS:

2/3 Elements	99212	99213	99214	99215
HPI	1-3 Elements	1-3 Elements	4 or More	4 or More
ROS	N/A	Related to HPI	Related to HPI & 2-9 Negs.	10
PFSH	N/A	N/A	1 item from any 3 areas	1 from each of 3 areas
EXAM	Affected body area only	6 Elements	12 Elements	All Elements
DECISION MAKING (See sheets in rooms for more detail)	1 Minor problem	2 or more minor problems	2 or more stable chronic	2 or more stable chronic or 1 with exacerbation

RETURN VISIT _____ PHYSICIAN SIGNATURE _____

Rehabilitation Physicians, PC
Relieving Pain and Restoring Lives

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is for all record requests. One request per form

RELEASE INFORMATION FROM:
Specify Provider/Organization Name and Facility Address

Organization Name _____

Address _____

_____

_____

RELEASE INFORMATION TO:
Specify Provider/Organization Name and Facility Address

Organization Name _____

Address _____

_____

_____

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

PATIENT'S FULL NAME _____

MAIDEN OR OTHER NAME _____

DATE OF BIRTH ____/____/_____ SSN/MEDICAL RECORD # _____

ADDRESS _____

Covering the period(s) of health care: **From** (Date) ___/___/_____ **To** (Date) ___/___/_____

1. **Information authorized for disclosure**, *if included in my records*:
   - ❑ Complete Health Record
   - ❑ Visit/Discharge Summary
   - ❑ Clinical Documentation of Physical
   - ❑ Documentation of Consultation
   - ❑ Progress Reports
   - ❑ Radiology and Diagnostic Imaging Reports
   - ❑ Pathology Reports
   - ❑ Laboratory tests *(please specify)*

     _____
   - ❑ Other *(please specify)*

     _____
2. **I understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Attention: HIPAA Compliance 28455 Haggerty Road Ste. 200 Novi, MI 48377. **I understand** that the revocation will not apply to information that has already been released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. **Unless otherwise revoked, this authorization will expire one year following the date signed**.
3. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact HIPAA Compliance at (248) 473-3310.
4. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Signed: Patient – (or Legal Representative, Parent or Legal Guardian) (Relationship if not Patient)

Date ____/____/_____ Witness: _____

_____

Official Use Only

Name/Title of Person Releasing Information: _____

Date ____/____/_____

Three Convenient Locations

Livonia Office • 19850 Middlebelt Road • Livonia, MI 48152 • Phone: 248-615-0060 • Fax: 248-615-1125

Novi Office • 28455 Haggerty Road, Suite 200 • Novi, MI 48377 • Phone: 248-893-3200 • Fax: 248-893-2950

Farmington Hills Office • 32255 Northwestern Highway, Suite 165 • Farmington Hills, MI 48334 • Phone: 248-893-3200 • Fax: 248-893-2950