Brecksville Physical Medicine

8930 Brecksville Road- Brecksville, OH 44141 Phone: (440)740-0696 FAX (440) 740-0697

Welcome to Our Office!

staff@brecksvillephysicalmedicine.com

Confidential Health History

Name:_____ Male / Female Date of Birth:___/_____/_____Age:_____
Address:_____City:_____State:_____Zip:_____
SS#: _____Phone:_____E-Mail:_____
Occupation_____Employer_____
Marital status: □ Single □ Married Spouse:_____
Primary insured Name: _____ Insured's date of birth____/____/_____
Emergency Contact:_____ Phone:_____
Who may we thank for referring you to the office?_____
Appointment reminder preference: □text □email □none monthly newsletter email preference: □yes □no

What is the reason for your visit?

What is your primary complaint?_____

severity: Pain Scale (no Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (remarkably severe)
frequency: ___occasional ___intermittent ___frequent ___constant
quality: ___dull ___aching ___stiffness ___sore ___spasm ___throbbing ___sharp ___occasionally sharp
___shooting ___stabbing ___burning ___tingling ___numbness
radiating to: ____Left /____Right : ____Arm ____Leg ____Other:_____
worse with:_____ **better with:**_____
time since onset: ___day(s) ___week(s) ___month(s) ___year(s) **change since onset:** __better __same __worse ___different
Is the condition related to: ____Injury ____Work-Injury ____Auto-Injury ____Personal Injury -Date of Injury:___/____/____
Have you received treatment for this condition? □Yes □No If so, what type?_____

Is there a secondary complaint?_____

severity: Pain Scale (no Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (remarkably severe)
frequency: ___occasional ___intermittent ___frequent ___constant
quality: ___dull ___aching ___stiffness ___sore ___spasm ___throbbing ___sharp ___occasionally sharp
___shooting ___stabbing ___burning ___tingling ___numbness
radiating to: ____Left /____Right : ____Arm ____Leg ____Other:_____
worse with:_____ **better with:**_____
time since onset: ___day(s) ___week(s) ___month(s) ___year(s) **change since onset:** __better __same __worse ___different
Is the condition related to: ____Injury ____Work- Injury ____Auto-Injury ____Personal Injury-Date of Injury:___/____/____
Have you received treatment for this condition? □Yes □No If so, what type?_____

Social history:

Do you exercise? □Yes □No If yes, how often? _____days/week What type of exercise?_____
Do you smoke? □Yes □No If so, how much? □ 1pack/day or less □More that 1pack/day
Do you drink alcohol? □Yes □No If so, how many per week? □ 1-4 □ 5-10 □ +10

History:

Medications:_____ Allergies:_____
_____ _____
_____
Vitamins:_____ Surgical history: (type/year)_____
Past Family History:_____ _____
_____ _____
_____ _____
_____ _____

Past and Present Medical History

8930 Brecksville Rd
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Patient Name _____ Date _____

Do you have a current or past personal history of any of the following?

	Current	Past
o None		
o Aneurysm	☐	☐
o Emphysema	☐	☐
o Kidney Disease	☐	☐
o Angina (Chest Pain)	☐	☐
o Epilepsy	☐	☐
o Kidney Disease	☐	☐
o Arthritis	☐	☐
o Heart Attack	☐	☐
o MRSA Infection	☐	☐
o Asthma	☐	☐
o Hepatitis Type	☐	☐
o Pacemaker	☐	☐
o Bone or Joint Infections	☐	☐
o HIV / AIDS	☐	☐
o Phlebitis (Blood Clots)	☐	☐
o Cancer	☐	☐
o High Cholesterol	☐	☐
o Pulmonary Embolism	☐	☐
o Chemotherapy / Radiation	☐	☐
o Hypertension (High Blood Pressure)	☐	☐
o Reaction to Anesthesia	☐	☐
o COPD	☐	☐
o Hyperthyroidism	☐	☐
o Seizures	☐	☐
o Congestive Heart Failure	☐	☐
o Hypothyroidism	☐	☐
o Stomach Ulcers	☐	☐
o Diabetes	☐	☐
o Stroke / TIA	☐	☐
o Tuberculosis	☐	☐

Please list any other conditions or details of conditions marked above:

_____

_____

Surgical and Family History

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Patient Name _____ Date _____

Past Surgical History

(Please list the year of surgery and use the additional lines as necessary)

_____ Knee arthroscopy (R/L)	_____ Shoulder arthroscopy (R/L)	_____ Thyroid
_____ Spine surgery (neck/back)	_____ Joint replacement	_____ Hernia repair
_____ Bypass (Heart or Limb)	_____ Cardiac catheterization	_____ Hysterectomy
_____ Ligament repair/replacement	_____ Pins/Plates/Screws	_____ Injections

Please list any other surgery you may have had in the past not listed above: _____

_____

_____

_____

Family History

(Please check all that apply to your family)

____ Bleeding disorder	____ Coronary artery disease	____Hepatitis
____ Cancer	____ Heart Disease/Attacks	____Seizures
____ Lung Disease	____ Rheumatoid arthritis	____Kidney disease

Please list any other disease that a member of your family may have that is not listed above: _____

_____

_____

_____

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Patient Bill of Rights

The Patient has the right to accurate and easily-understood information about their health plan, health care professionals, and health care facility. If there are any confusions or misunderstandings, help will be provided.

If the Patient has severe pain, an injury, or sudden illness that makes them believe that their health is in danger, the Patient has the right to be screened and stabilized using emergency services.

The Patient has the right to know their treatment options and take part in decisions about their care. Parents, guardians, family members, or others that they choose can speak for them if they cannot make their own decisions.

The Patient has a right to considerate, respectful care from their doctor, health plan representatives, and other health care providers that does not discriminate against them.

The Patient has the right to talk privately with health care providers and to have their health care information protected. The Patient also has the right to read and copy your own medical record.

The Patient has the right to a fair, fast, and objective review of any complaint there is against the health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of health care facilities.

By signing this Bill of Rights you agree that there is an understanding of the above statements.

Patient Signature: _____ **Date:** _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

A Notice of Privacy has been made available to me by Brecksville Physical Medicine. This describes how my health information may be used or disclosed and my rights under the Health Insurance Portability and Accountability Act (HIPAA).

By signing this authorization you acknowledge and agree that Brecksville Physical Medicine may use or disclose medical records for the purpose(s) of receiving payment, insurance benefits, insurance denials, insurance audits, intent to reconcile account, intent to help patient and training purposes.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient Signature _____ **Date** _____
Would you like a copy of the Privacy Notice (4 pages)? _____ Yes _____ No

Optional: In addition I would like to give my consent for release of health or financial information to the following individual (this does not include copies of medical records or reports):

Name _____ Relationship _____ Date of birth _____

Patient Signature _____ Date _____

CONSENT FOR TREATMENT / FINANCIAL POLICY

I _____(print name) do hereby agree and give my consent for Brecksville Physical Medicine to perform diagnostic procedures, render medical care and treatment judged medically necessary by our physicians.

I understand and agree that health and accident insurance policies are an arrangement between insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credit to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature _____ **Date** _____

Consent to treat a minor

Patient Name: _____

Guardian Name: _____

Guardian Signature: _____ Date _____