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ProHealth PHYSICAL MEDICINE
HEALTH ELEVATED

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Date: _____ Patient Name_____ D.O.B._____
E-Mail _____ Cell Phone _____
Address _____ City_____ State_____ Zip_____
Whom may we thank for referring you? _____

Check Appropriate Box**:** □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated □ Partner
□ Male □ Female □ Non Binary
Spouse or Parent/Guardian's name_____ Phone_____
Emergency Contact (□ **Check if Same as Above**)_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____
Signature of Parent or Guardian Date
Parent/guardian's employer _____ Work Phone _____

Which of the following services would you be interested in receiving more information on:

☐Hormone Optimization	☐Physiotherapy / Rehabilitation	☐B-12 Injections
☐Chiropractic Care	☐Medical Weight Loss	☐Vitamin Drip Therapy
☐Trigger Point Injections	☐Stem Cell Therapy	☐Spinal Decompression Therapy
☐Class IV Laser Therapy	☐Platelet Rich Plasma (PRP) Therapy	☐Peptides

Past Medical History (Have you ever had the following: (circle "yes" "no" or leave blank if you are uncertain.)

Epilepsy	NO	YES	Anemia	NO	YES	Stroke	NO	YES	High Blood Pressure	NO	YES
Arthritis	NO	YES	Migraine Headaches	NO	YES	Hepatitis	NO	YES	Bleeding Tendency	NO	YES
Hernia	NO	YES	Diabetes	NO	YES	Heart Attack	NO	YES	Depression	NO	YES
Anxiety	NO	YES	Cancer (explain below)	NO	YES						

Previous Hospitalizations/surgeries/serious illnesses When? Hospital or City/State
_____ _____ _____
_____ _____ _____

Medication: (include non-prescription)
_____

Medication Allergies: _____

Patient Social History:

Use of Alcohol Never: _____ Lightly: _____ Moderately: _____ Daily: _____
Use of Tobacco Never: _____ Lightly: _____ Moderately: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency: _____

Family Medical History:

Relationship Age Disease If Deceased, Cause of Death
_____ _____ _____ _____
_____ _____ _____ _____

Patient Name: _____

Other Symptoms or Concerns (check any that apply)

☐ Hot Flashes	☐ Hair Loss / Thinning	☐ Fatigue	☐ Dry Eyes
☐ Night Sweats	☐ Cold Hands / Feet	☐ Joint Pain	☐ Decreased Muscle Mass
☐ Urinary Incontinence	☐ Brittle Nails	☐ Acne	☐ Difficulty Sleeping
☐ Weight Gain	☐ Dry / Flaking Skin	☐ Facial Hair	☐ Decreased Libido

Cancellation and No-Show Policy:

Your appointments are reserved especially for you and are very important to the ProHealth Physical Medicine team. We understand that sometimes schedule changes are necessary and therefore, we respectfully request at least 48 hrs. notice for cancellations or rescheduling of appointments. Because of the busy nature of our office, this notice allows us time to offer your appointment to another patient. Missed scheduled appointments, without providing 24 hours advance notice, will be charged a $50 fee for the first, $75 for the second and $100 for every visit thereafter.

I understand and agree that (regardless of any health insurance or medical benefits I have), I am ultimately responsible to pay Boulevard Medical Group, ProHealth Physical Medicine, Garrett Glapa, and/or Dr. Abraham Grosswasser as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for all professional services rendered and for any supplies, tests, or medications provided.

Health Insurance Assignment and Release:

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

Please provide the primary subscriber on your insurance plan: ☐Self **OR** Name _____ DOB _____

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signature: _____DOB: _____Date:_____

PATIENT HISTORY

Patient Name: _____DOB: _____

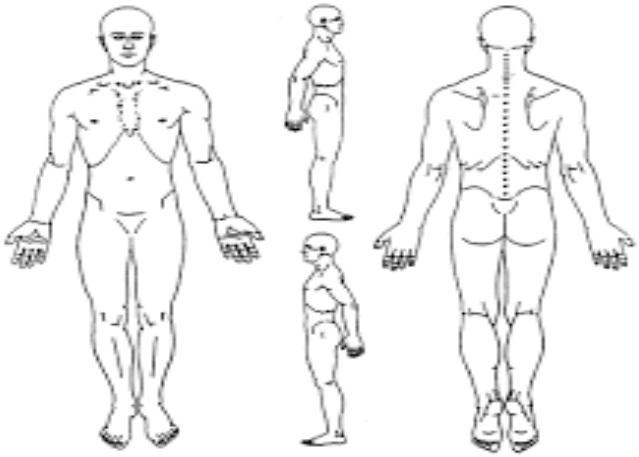
1. What is your main complaint? _____
2. On the scale below, please circle the severity of your main complaint (At it's worst)

NONE		SLIGHT		MILD		MODERATE			SEVERE
1	2	3	4	5	6	7	8	9	10

3. On the scale below please circle the percentage of time you experience your main complaint:

	OCCASIONAL			INTERMITTENT			FREQUENT		CONSTANT
0%	10%	20%	30%	40%	50%	60%	70%	80%	90-100 %

4. How long have you been experiencing your main complaint? _____
5. On the diagram below, use the following letters to mark the location you are experiencing each sensation:
   A: ache **B:** Burning pain **C:** Cramping **D:** Dull pain **N:** Numbness **T:** Tingling **R:** Throbbing pain



6. When do you notice it most? AM PM (please circle one)
   How long does it last? _____mins _____hrs
7. What makes It feel better?_____
8. What makes it feel worse?_____
9. Have you ever had this problem in the past? Yes No
10. Have you seen another provider for this problem? Yes No
11. Have you lost time from work because of it? Yes No
    Dates? _____ to _____
12. Since your last visit have you experienced:
    1. Any change in your history? Yes or No
    2. Any change in medication? Yes or No

Do you have pain and /or difficulty performing any of the following activities?

Personal Care _____
Lifting _____
Reading _____
Concentrating _____
Work _____
Driving _____
Sleeping _____
Recreation _____
Sitting _____
Standing _____
Social Life _____

No, I can perform all of these activities _____

To The Best of My Knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian **Date**

_____ _____

Signature of Examiner / Clinician **Date**

Patient Questionnaire – Auto-Accident

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: _____ AM / PM

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital: _____ Stay Duration? _____

Taken by ambulance? ☐ Yes ☐ No

Describe how the Accident took place:

_____

_____

_____

_____

Describe how you felt at the time of the accident:

_____

_____

Describe how you felt the next day:

_____

_____

Auto-Accident Specific Information:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Type of Impact: ☐ Rear end ☐ Front ☐ Side Impact ☐ Roll Over

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Wearing Seat belt? ☐ Yes ☐ No **Shoulder Harness:** ☐ Yes ☐ No

Is the car equipped with airbags? ☐ Yes ☐ No **Did they deploy?** ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No **Did you brace yourself for impact?** ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact were you: ☐ Thrown forward ☐ Thrown backwards ☐ Thrown sideways ☐ Other _____

Did your body hit anything inside the car? ☐ Yes ☐ No **Body Part:** _____

What part of the car did your body hit? _____

Head trauma? ☐ Yes ☐ No **Loss of Consciousness?** ☐ Yes ☐ No For how long? _____

Imaging taken? ☐ X-rays ☐ MRIs **Areas:** ☐ Neck ☐ Mid-back ☐ Low-back ☐ Other Imaging

_____

Additional Information Related to the Condition:

Have you ever had the same or similar condition or symptoms previous to the accident? ☐ Yes ☐ No

When? ___/___/___

Describe:_____

_____

Please indicated any other healthcare providers whom you have seen due to the accident:

Name	Type of Licensure	Phone Number
_____	_____	_____
_____	_____	_____

Do you have follow-up appointments? :

_____

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness in arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness in legs/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever	☐ Fatigue
☐ Irritability	☐ Loss of Smell	☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw pain
☐ Loss of strength - arms	☐ Loss of strength - legs	☐ Burning muscle pain	☐ Difficulty swallowing	☐ Sharp/shooting pain	

Other _____

Have you experienced changes to:

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder

☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite

Please Explain:

_____

Medical History:

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ___/___/___

2) _____ ___/___/___

3) _____ ___/___/___