Co-pays for EMG testing will be billed after your Insurance Co. has been billed. Co-pays for all other services are due at time of service.

Ronald M. Yarab Jr., MD • Michael T. Engle, MD
Sean T. McGrath, MD • Meredith L. Konya, MD

Patient ____ Date of Birth ______________ Sex: M F
Last Name First Name Initial

Street Address ______________________________ City ________________State ________Zip _________

Social Security # _____________________ Home Phone ______________ Cell Phone _________________

Email _________________________ Employer ____________________ Phone ____________________

Spouse/Parent____________________________ DOB ____________Social Security # _________________

Home Phone______________________________ Cell Phone _____________________________________

Second Parent ____________________________ DOB ____________ Social Security #________________

Home Phone # ____________________________ Cell Phone # ___________________________________

Emergency Contact ____ Phone # _______________________

Referring Doctor _____________________________ Family Doctor __________________________________

How did you hear about our practice?____

INSURANCE INFORMATION **Please make sure we have a copy of your most recent insurance cards.**

1st Ins. Policy Holder _________________________________ Social Security # _______________________

2nd Ins. Policy Holder ________________________________ Social Security # _______________________

ARE YOU NOW PART OF A HOSPICE PROGRAM? YES ____ NO _____

Are you seeing us today due to a Worker's Compensation or an Auto Accident?
Yes ____ NO _____ Injury Date: ____________________________

***** IF YES, PLEASE ALSO FILL IN THE ACCIDENT INFORMATION SHEET *****

AUTHORIZATION: I hereby authorize PM&R North, Inc./All Points Physical Medicine to release any information concerning my illness and treatments, and that of my dependents. I also authorize payment of medical benefits to PM&R North for services rendered. I understand that payment for services is my obligation regardless of insurance or third party involvement. This authorization applies for future services.

Signature ____Date_________________________

ALL POINTS
PHYSICAL MEDICINE • REHABILITATION • FITNESS

Name: ______________________________ Date: ______________

1. Please describe your pain by checking all that apply:

❑ Sharp ❑ Burning ❑ Achy ❑ Deep ❑ Knife-like ❑ Twisting ❑ Pressure ❑ Heavy ❑ Gnawing

2. On a scale of 1-10, how severe is your pain? 1 being very little or no pain to 10 being very severe pain: __________

3. How long have you had this pain? ______________________________

4. What makes your pain worse? ______________________________

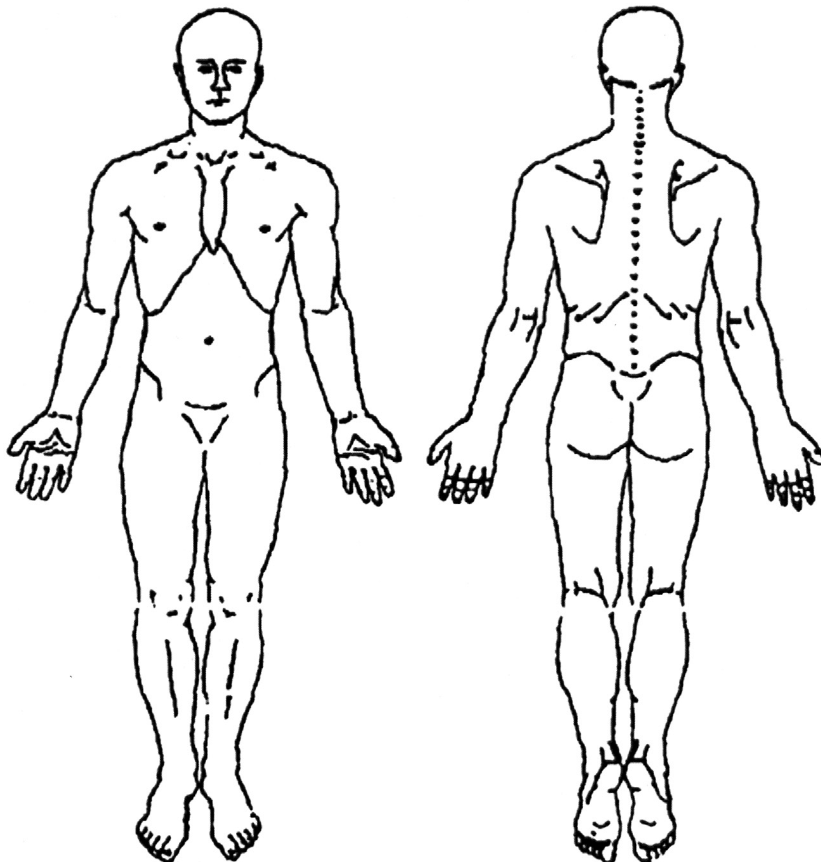
____

5. What makes your pain better? ______________________________

____

6. Please mark the figure below with the location of your symptoms.

Mark pain areas as XX   Mark numbness and/or tingling as OO



ALL POINTS
PHYSICAL MEDICINE • REHABILITATION • FITNESS

Medication Log

Patient:____ DOB___________________

Phone H:______________________Phone W:_____________________Phone C:_________________

Pharmacy____Phone________________________

Known Drug Allergies:____

Medications patient is currently on.

Date	Medication Name	Strength	Qty.	Freq.	DX Prescribed for	Prescribing Doctor

Medications prescribed by PM&R North Physician

Date	Medication	Strength	Qty.	Freq.	Refills	Diagnosis	Called in	Initials

ALLPOINTS

Physical Medicine, Rehabilitation, Fitness

Name:____ Date:______________________________

Date of Birth: ___________________________________

Please check the following that apply to you:

	Tobacco use/type:		Coffee/cups per day:
	Alcohol		Highest grade level completed:
	Illicit drugs		

Please briefly describe your job/work duties. Leave blank if you do not work outside the home:

____

____

Please check conditions which you currently suffer from, or have suffered from in the past:

	Heart disease		Cancer/type:		Kidney stones
	Heart attack		Arthritis		Thyroid problems
	Stroke		Diabetes		Fibromyalgia
	Asthma		Drug/alcohol dependence		Prior back injuries
	Emphysema		Stomach ulcers		

Other:____

____

On the left is a list of common conditions that tend to run in families. Please put an X in the box that a relative suffers from. Put additional siblings, if more than 3, under "Other close relatives." List only blood relatives, not adopted, or "step" relatives. Use "Other" lines to note conditions in your family not already listed.

CONDITION:	Mom	Dad	Sibling 1	Sibling 2	Sibling 3	Children	Other close relatives
Heart disease							
Diabetes							
Cancer							
Rheumatological conditions							
Psychiatric problems							
High blood pressure							
Stroke							

Other:____

____

____

Name:________________________________ DOB:_____________ Date:________________

Below are common symptoms which may suggest the presence of an ailment involving a particular body system. Please CIRCLE the particular symptoms you are currently troubled by.

Musculoskeletal:

Neck pain
Shoulder pain
Upper arm pain
Elbow pain
Jaw pain
Joint swelling
Joint stiffness
Hand pain
Upper back pain
Low back pain
Upper leg or hip pain
Lower leg or hip pain
Ankle or foot pain

Neurological/Psychiatric:

Memory loss
Depression
Insomnia
Headaches
In-coordination
Fainting
Convulsions
Dizziness
Loss of balance

Cardiovascular:

Rapid heartbeat
Chest pain
Irregular heartbeat

Constitutional:

Fever
Hair loss
Chills
Loss of appetite
Weight gain/loss

Eyes & Ears:

Vision Loss
Eye pain
Dry eyes
Tinnitus (ear noise)
Hearing loss
Ear pain

Respiratory:

Shortness of breath
Chronic cough
Chronic sinusitis

Gynecological:

Pain during menstruation
Irregular menstrual flow
Menopausal symptoms

Genitourinary:

Painful urination
Urethral discharge
Loss of bladder control

Gastrointestinal:

Abdominal pain
Constipation
Difficulty swallowing

Skin:

Rashes
Persistent itching
Dermatitis or eczema

Review of systems completed with patient by Physician on:__________________________.

(sign/date)
Updated ______________________________
___________________ ___________________
___________________ ___________________

822 E. Western Reserve Rd. • Poland, OH 44514 • P: 330.758.8223

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
2. Obtain payment from third-party payers
3. Conduct normal healthcare operations such as quality assessments and Physician certifications

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____________________

Relationship to Patient: ____________________

Signature: ____________________

Date: ____________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

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