SUPERIOR HEALTHCARE PHYSICAL MEDICINE AND REHAB

38 Westgate Parkway, Asheville, NC 28806 Phone: 828-505-4886

PATIENT INFORMATION

VRC:(OFFICE FILLS OUT)_____

Full Name:_____ Sex: □ Male □ Female
(First) (Middle) (Last)

Age: _____ DOB:_____ SSN# _____Cell Phone: _____

Race:□ Caucasian □African American □Asian □Latin American □Other

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

Marital Status: □Single □Married □Divorced □Widowed □Minor □Other

Occupation: _____ Employer: _____

Emergency Contact: Name: _____ Relationship: _____Phone: _____

How did you hear about our practice? _____

ACCIDENT INFORMATION

Is this visit due to an accident? □Yes □No If yes, what type? _____

Has it been reported? □Yes □No If yes, to whom? _____

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare, if he/she is aware such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. My consent to care will last for 12 months from the start date of my initial exam/visit to Superior Healthcare Physical Medicine and Rehab.

I agree to settle any claim or dispute that I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved and final determination will be made with Superior Healthcare Physical Medicine and rehab authorized delegates.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Superior Healthcare Physical Medicine and Rehab. Would you like to receive a paper copy of the practices? □Yes □No Initial: _____ If no, I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

_____ I acknowledge that Superior Healthcare Physical Medicine and Rehab will leave reminder messages on my answering machine. I acknowledge if I should have a problem or question, I may speak with the Privacy Officer, Dr. Andrew Wells, about my concerns.

_____ I give permission to Superior Healthcare Physical Medicine and Rehab to contact my primary care provider, in order to achieve greater results. These lines of communication will only benefit care and progress during the treatment plan.

SIGNATURE: _____ DATE: _____

PERSONAL HEALTH HISTORY

Who is your primary care physician? (Doctor and/or Practice) _____
Are you currently under drug and/or medical care? □Yes □NO If Yes, explain: _____
Please list or provide a printed copy of any medications/supplements you are currently taking (include dosage and frequency):_____
_____(See attached sheet if you need more space)
Please list any surgeries and/or hospitalizations you have had (type & date): _____
_____(See attached sheet if you need more space)
Please list any allergies: _____
Do you exercise: □Yes □No If Yes, How often? _____ What do your work activities mostly involve? _____
What is your daily/weekly intake of the following: Caffeine ____ cups/day Alcohol ____ drink/weeks Cigarettes _____ packs/day

Please check to indicate if you are currently experiencing any of the following conditions:

□Neck Pain/Stiffness	□Pins/Needles in Arms	□Light Bothers Eyes	□Sudden Weight	□Loss Nausea
□Back Pain/Stiffness	□Pins/Needles in Legs	□Depression	□Sudden Weight Gain	□Cold Feet
□Knee Pain R/L	□Asthma	□Dizziness	□Loss of Taste	□Headaches
□Leg Pain R/L	□Fatigue	□Nervousness	□Loss of Memory	□Chest Pain
□Hip Pain R/L	□Sleeping Difficulties	□Tension	□Jaw Problem	□Fever
□Shoulder Pain R/L	□Loss of Smell	□Cold Sweats	□Constipation	□Fainting
□Elbow Pain R/L	□Allergies	□Stomach Problems	□Shortness of Breath	□Other _____
□Wrist Pain R/L	□Blurred Vision	□Night Pain	□Bowel/Bladder Changes	

Which of the above is the worst? _____
How long have you had it? _____
How often does it occur? _____
What have you done that helps this problem? _____
What activities would you like to do if this was not a problem? _____
Does this cause you to be: □Moody □Irritable □ Interrupt Sleep □ Restricts your daily activities
Does this affect your work: □Decision Making □Poor Attitude □Decreased Productivity □Unable to work long hours
Does this affect your life: □Lose patience □Restrict activities □Hinders abilities to exercise □Interferes with hobbies
What have you tried to help relieve/get rid of this problem and how much did it help?
□Medications: Little, Some, Much □Physical Therapy: Little, Some, Much □Chiropractic: Little, Some, Much
□Exercise: Little, Some, Much □ Nutrition: Little, Some, Much □Stretching: Little, Some, Much
□Other: _____

Please check to indicate if you have ever had any of the following:

□Aids/HIV	□Cancer	□Hepatitis	□Osteoporosis	□Stroke	□ Alcoholism	□Cataracts
□Hernia	□Pacemaker	□Suicide Attempt	□Allergy Shots	□Herniated Disc	□Anemia	□Chicken Pox
□Herpes	□Tonsillitis	□Pinched Nerve	□Anorexia	□Diabetes	□Pneumonia	□Tuberculosis
□Appendicitis	□Emphysema	□Kidney Disease	□Polio	□Arthritis	□Epilepsy	□Asthma
□Fractures	□Measles	□Prosthesis	□Ulcers	□Glaucoma	□Migraines	□Breast Lump
□Goiter	□Miscarriage	□Bronchitis	□Gonorrhea	□Mononucleosis	□Bulimia	□Gout
□Scarlet Fever	□Mumps	□Heart Disease	□Multiple Sclerosis	□Chemical Dependency		□Rheumatic Fever
□Parkinson's Disease	□Thyroid Problems	□Liver Disease	□Tumors/Growths	□Psychiatric Care	□Bleeding Disorders	
□Prostate Problems	□Typhoid Fever	□Venereal Disease	□Whooping Cough	□Rheumatoid Arthritis	□Vaginal Infections	

□Other: _____
Have any immediate family members have/had: Heart Disease, Diabetes, Stroke, or Cancer If yes, relationship and what?
_____
_____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____ DATE: _____

Medications and Supplements List (Include Dosage and Frequency):

Surgeries and Hospitalizations List (Type and Date):

SIGNATURE: _____ DATE: _____