REHABILITATION MEDICINE SPECIALISTS

Patient Registration Form

Physician: ______________________ Today's Date: __________________ New ☐ Update ☐

Who referred you: __________________________ Primary Care Doctor: ______________________

Patient Information

Social Security Number	Last Name	First Name	MI
Address	City	State	Zip Code
Home Phone	Mobile/Work Phone	Marital Status Married ☐ Divorced ☐ Single ☐ Widowed ☐	
Date of Birth / /	Sex M ☐ F ☐	Allergies	

Emergency Contact Name: Phone:

Employer

Employed By:	Phone Number	Fax Number	
Address	City	State	Zip Code
Occupation	FT/ PT	Date of Hire:	

Guarantor/Responsible Party Information

Social Security Number	Last Name	First Name	MI
Address	City	State	Zip Code
Home Phone	Work Phone		
Date of Birth / /	Sex M ☐ F ☐	Relationship to Patient:	

Is your injury due to employment or an automobile accident? Yes ☐ No ☐ If Yes, please complete the attached Employment/Auto Accident Information Sheet

Primary Insurance Information

Please provide a copy of the front and back of your insurance cards, even if you believe Worker's Comp. or Auto Insurance will pay.

Insurance Company Name:	ID#	Group#
Subscriber's Name:	Date of Birth:	Relationship to Patient:
Employer:		

Secondary Insurance Information

Insurance Company Name:	ID#	Group#
Subscriber's Name:	Date of Birth:	Relationship to Patient:
Employer:		

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize the physician to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or Medicare benefits to be paid directly to the physician. I further agree that a photocopy of this document is to be considered as valid as an original.

Guarantor Signature: ____________________________ Date: ____________________

Pharmacy Name/Location: __________________________ Pharmacy Telephone: __________

Personal/Work Email address: ____

REHABILITATION MEDICINE SPECIALISTS, INC.
Patient History Form

Name: ______________________ Today's Date: ______________

Date of Birth ______________ Height ____________ Weight ____________

A. 1. Referring doctor name and address ______________________

If not referred, how did you choose our office? ______________________

2. Primary Care doctor name and address ______________________

3. Chief Complaint: ______________________

4. Your age: Years __________ Months __________ 5. Sex M ☐ F ☐

6. How long has this problem been present? ______________________

7. Has your problem worsened recently? No ☐ Yes ☐ How recently? ______________

8. What started the problem? ______________________

Any trauma? ______________________

On a scale from 1-10 where 1 equals no pain and 10 equals severe pain:

What is your pain at its worst? ______

What is your pain at its best? ______

What is your pain most often? ______

What is your pain right now? ______

9. Treatments have included: ☐ No medicines, therapy, manipulations, injections, braces or casts.

☐ Physical therapy, exercise
☐ Massage and ultrasound
☐ Traction
☐ Manipulation
☐ Tens Unit
☐ Anti-inflammatory medication
☐ Narcotic medication
☐ Braces
☐ Steroid injections
☐ Cast

Other ______________________

10. List pain medicines and dose taken for this problem: None ☐

____

____

11. Previous doctors seen about this problem:

(List dates, specialties, city, and treatments) None ☐

Doctor	Specialty	City (if not St. Louis)	Treatments

12. Tests done to evaluate your problem None ☐

Test	Date	Where	Result (if known)
Plain x-rays			
MRI			
EMG'S			
BONE SCAN			
CT SCANS			
Other			

13. Because of this problem, I have filed or plan to file

Lawsuit ☐ Worker's Compensation Claim ☐ Neither ☐

If you have an attorney, please provide his/her name: ______________________

B. Review of Systems: (Check all that apply) ☐ None apply

☐ Reading Glasses
☐ Change of Vision
☐ Loss of Hearing
☐ Ear Pain
☐ Hoarseness
☐ Nosebleeds
☐ Difficulty Swallowing
☐ Morning Cough
☐ Shortness of Breath
☐ Fever or Chills
☐ Heart or Chest Pain
☐ Abnormal Heart Beat
☐ Swollen Ankles
☐ Poor Appetite

☐ Toothache
☐ Gum Trouble
☐ Nausea or Vomiting
☐ Stomach Pain
☐ Ulcers
☐ Frequent Belching
☐ Frequent Diarrhea
☐ Frequent Constipation
☐ Hemorrhoids
☐ Frequent Urination
☐ Burning on Urination
☐ Difficulty Starting Urination
☐ Calf Cramps w/ walking
☐ Get up more than once at night to urinate

☐ Frequent Headaches
☐ Blackouts
☐ Seizures
☐ Frequent Rash
☐ Hot or Cold Spells
☐ Recent Weight Change
☐ Nervous Exhaustion

Women Only:
☐ Irregular Periods
☐ Vaginal Discharge
☐ Frequent Spotting

Is your primary doctor aware of the above checked problems? Yes ☐ No ☐

C. Medical History: (Check all that apply) ☐ None apply

☐ Heart Attack
☐ Heart Failure
☐ High Blood Pressure
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Ankylosing Spondylitis
☐ Gout
☐ Osteoporosis
☐ Diabetes
☐ Stroke
☐ Seizures

☐ Mental Illness
☐ Kidney Stones
☐ Kidney Failure
☐ Cancer
☐ Alcoholism
☐ Lung Disease
☐ AIDS
☐ Tuberculosis
☐ Asthma
☐ Blood Clot in Leg
☐ Blood Clot in Lung

☐ Stomach Ulcers
☐ Liver Trouble
☐ Hepatitis
☐ Thyroid Trouble
☐ Bleeding Disorders
☐ Anemia
☐ Serious Injuries (explain)

____

____

____

____

D. Surgical History: (Previous surgeries, Surgeon, and Date) None ☐

Operation	Surgeon	Date

E. Family History: (Check all that apply) ☐ None apply

☐ Stroke
☐ Heart Trouble
☐ High Blood Pressure
☐ Diabetes
☐ Arthritis

☐ Gout
☐ Seizures
☐ Spine Problems
☐ Mental Illness
☐ Kidney Trouble or Stones

☐ Cancer
☐ Bleeding Disorders
☐ Alcoholism

Other ____

F. Medications you take: None ☐

____

____

____

G. Allergies to Medications: No known drug allergies ☐

Medication	Reaction (rash, swelling, wheezing, shock, upset stomach, other)
______	______
______	______
______	______
______	______
______	______
______	______

H. Social History

Work Status: Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disabled ☐

Occupation (current or most recent) ______

Number of living children ______ I live: ☐ alone ☐ with ______

Steps to enter home ______ Steps inside home ______

Tobacco Use: ☐ Never ☐ Cigar ☐ Chew ☐ Pipe
☐ Cigarettes ______ packs per day ______ years
☐ Quit When ______ after smoking ______ packs per day for ______ years

Alcohol Use: ☐ Never or Rare ☐ Social ☐ Frequent
☐ Alcoholic ☐ Recovering Alcoholic

Drug Use: ☐ Never ☐ Currently ☐ In the past

FUNCTION:

Do you require assistance with mobility at home?

☐ Repositioning in bed ☐ Walking ☐ Hygiene
☐ Transferring ☐ Managing Wheelchair ☐ Eating
☐ Standing ☐ Propelling Wheelchair ☐ Dressing
☐ Toileting ☐ Bathing

Do you require assistance with:

☐ Meal Preparation ☐ Laundry ☐ Housework ☐ Mobility in the community
☐ Other ______

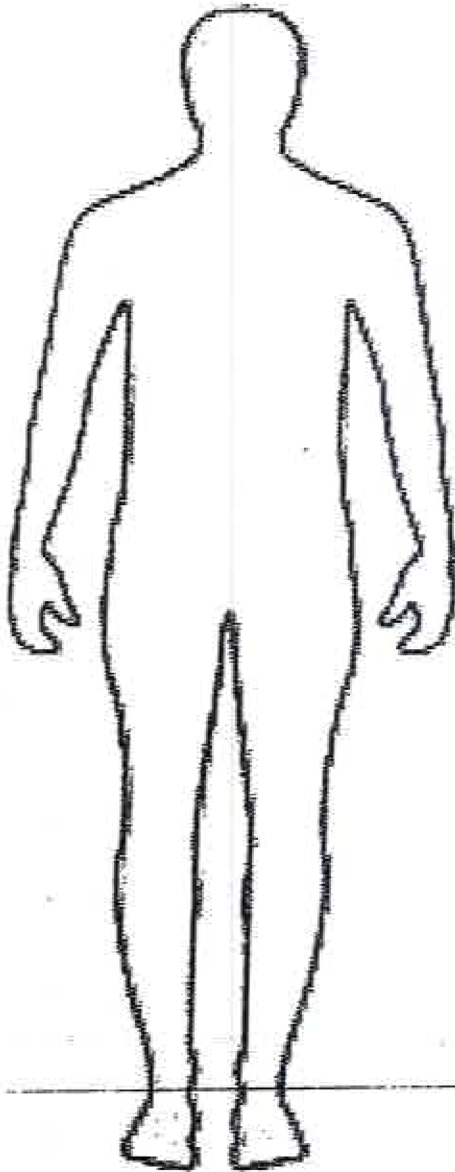
List Aids: ______

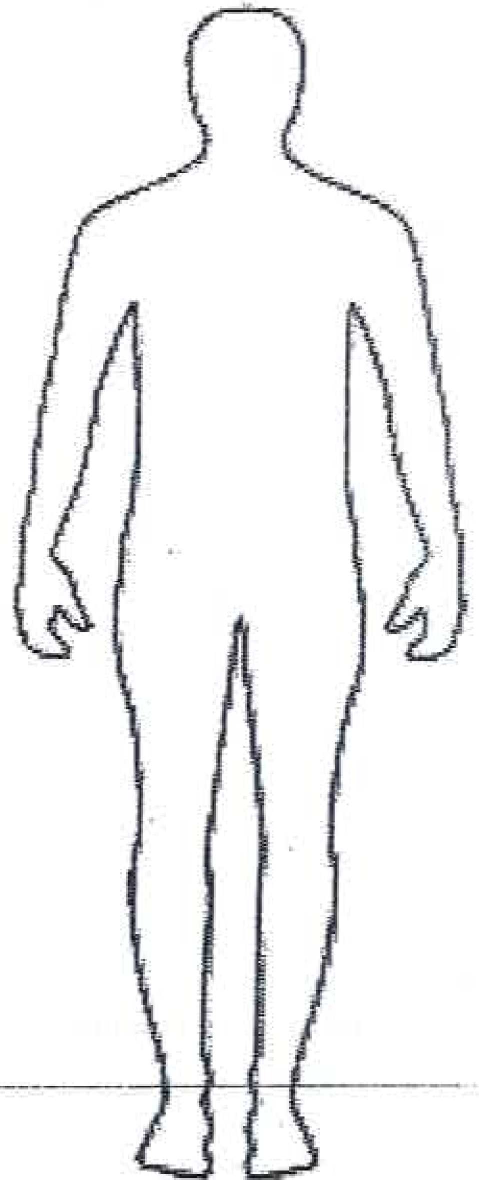
List Helpers: ______

I am independent: ☐ at home ☐ in the community

Are you able to sleep at night? ______ How many hours? ______

(Please continue to the next page)





Please mark a "N" anywhere you are experiencing NUMBNESS
Please mark a "P" anywhere you are experiencing PAIN
Please mark a "W" anywhere you are experiencing WEAKNESS

Patient Signature ____________________

Physician Review ____________________ Date ____________