ADVANCED PHYSICAL MEDICINE
RESTORE.RENEW.REGENERATE

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www.apmr3.com

Please fill out the application entirely and legibly.

PERSONAL INFORMATION

Name_____Nickname_____

Address_____

City _____State _____ Zip _____

Phone _____Email_____

We will need to contact you by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth _____Social Security_____

Spouse's Name _____Phone Number _____

Your Occupation _____Retired? Yes No

Primary Care Physician: _____

Address: _____

Telephone: _____

WORKERS COMPENSATION / PERSONAL INJURY:

Were you recently involved in a motor vehicle accident or worker's compensation case? YES NO If yes, please inform the front desk.

PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

Insured's Name: _____ Insured's SS#: _____Insured's DOB: _____

Patient's Relationship To Insured: ___ Self ___Spouse ____Child ___Other: _____

Name of Insurance Company: _____

Address: _____

Insurance Phone #: _____ Policy Number: _____

SECONDARY INSURANCE

Insured's Name: _____ Insured's SS#: _____

Name of Insurance Company: _____

Address: _____

Insurance Phone #: _____ Policy Number: _____

REVIEW OF SYSTEMS

General

___ Fever

___ Weight Loss

___ Weight Gain

___ Body Aches

___ Cannot Sleep

___ Decrease in appetite

___ Weakness

Integumentary

___ Mole (increased size)

___ Mole (change in color)

___ Rash

___ Hives

___ Itching

___ Hair Loss

___ Increased in dryness of skin

___ Blisters

Ears/Nose/Throat

___ Hearing Loss

___ Ear Infection

___ Earring Ringing

___ Hoarseness

___ Difficulty Swallowing

___ Sinus Problems

Respiratory

___ Wheezing

___ Shortness of Breath

___ Cough

___ Coughing up blood

___ Sleep Apnea

Cardiovascular

___ Chest Pain or Pressure ___ Irregular or rapid heartbeat ___ Leg Cramps while walking

___ Shortness of breath when lying flat

___ Swelling of feet/ankles

Gastrointestinal

___ Heartburn or indigestion

___ Vomiting

___ Diarrhea

___ Pain in abdomen

___ Blood in stool

___ Change in bowel habits

___ Constipation

___ Hiatal Hernia

___ Nausea

___ Reflux

Renal/Urinary

___ Difficulty Urinating

___ Frequent Urination

___ Difficulty with Stream ___ Hematuria (Blood in Urine) ___ Urinary Incontinence ___ Waking at night to Urinate ___ Urgency

Gynecological(women only)

___ Heavy Menstrual Flow

___ Hot Flashes

___ Vaginal Discharge

Musculoskeletal

___ Joint Pain

___ Joint Swelling

___ Back pain and stiffness

___ Arthritis

___ Muscle Pain or cramps

Neurological

___ Seizures

___ Speech Delay

___ Delayed Motor Skills

___ Poor Balance

___ Confusion

___ Dementia

___ Dizziness

___ Headaches

___ Numbness

___ Slurred Speech

___ Tremors

___ Weakness

Endocrine

___ Excessive Thirst

___ Excessive Hunger

___ Fatigue

___ Hyperactivity

Hemato/Lymphatic ___ Swollen Lymph Nodes ___ Bleeds Easily

___ Bruises Easily

Emotional

___ ADD/ADHD

___ Anxiety

___ Depression

___ Panic Attacks

Allergies/Immunological

___ Seasonal Allergies ___ Allergies: Shrimp ___ Allergies: Eggs

Eyes

___ Blurred Vision

___ Double Vision

___ Recent Loss of Vision

___ Excess Tearing

___ Redness

___ Droopy Eyelid

___ Discharge from eye

___ Eye Pain

___ Flashes/Floaters

[ ] ALL OF THE ABOVE SYSTEMS WERE REVIEWED WITH ***NEGATIVE RESPONSES***

MEDICATIONS LIST:

Please list off your medications including prescribed, over the counter, supplements, and vitamins down below:

Initial Medical Screening Questionnaire

Name: _____ Date:_____

Medical History:

_____ _____

_____ _____

Family History : Please circle all that apply : Heart Disease Stroke Diabetes Cancer _____

Surgical History: Joint Repair/Replacement ? Spinal Surgery? Y / N

Please let us know IF YOU HAVE or HAVE HAD any of these followings:

Chronic Allergies/Recent Colds/ Flu / Cough YES NO

Cancer of the ( ) YES NO

Thyroid Problems/ Chronic Steroids/ Autoimmune Disease YES NO

Hepatitis/ AIDS/HIV+ YES NO

Diabetes YES NO

Stroke/ Chronic Headaches/ Seizures YES NO

Heart/ Blood Vessel Problems YES NO

Pacemaker/ Cardiac Stents / Artificial Valves YES NO

Chronic Blood Thinners YES NO

High Blood Pressure YES NO

Bone Disease/ Broken Bones/ Artificial Joints/ Screws YES NO

If YES, Which bone(s)? _____

Prostate Disease/ Hormone Therapy YES NO

Alcohol Addiction/ Depression/ Anxiety YES NO

COPD/ CHF/ Asthma/ Shortness of Breath ? Wheezing/ Emphysema YES NO

Recent Bronchitis / Pneumonia / Bronchospasm YES NO

Used illegal or IV Drugs YES NO

Chiropractic Treatment YES NO

Are you or do you think you **MAY** be pregnant? YES NO