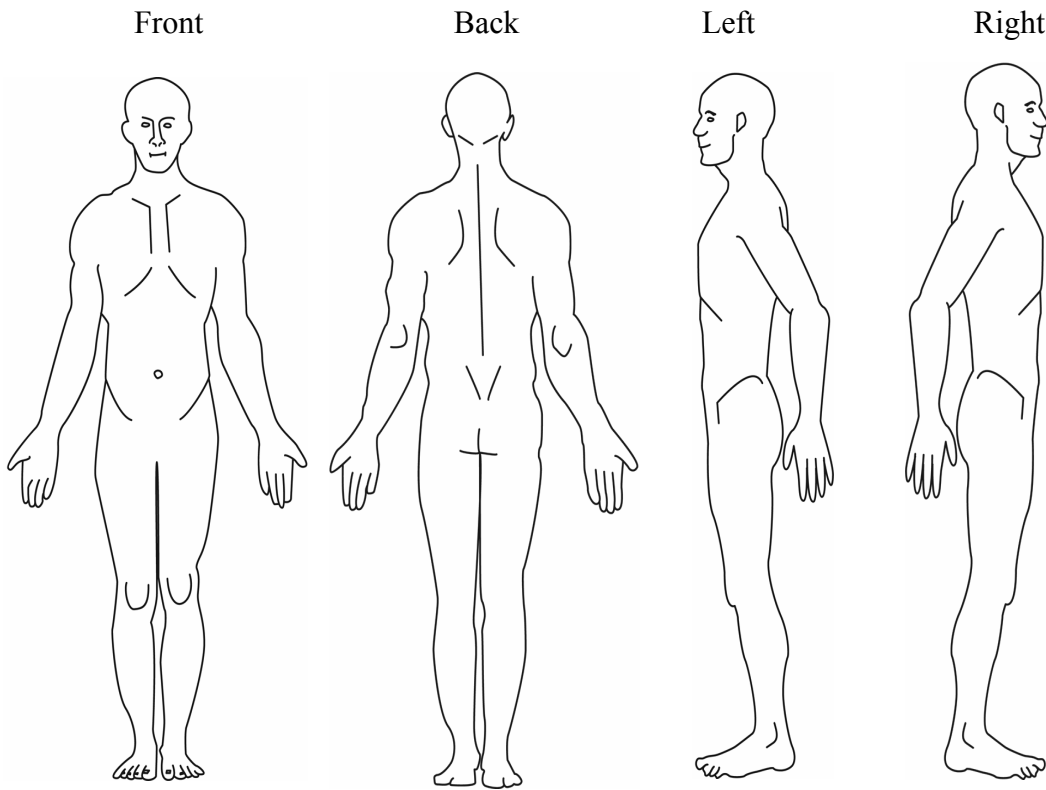


Patient Name: _____

Using the following symbols, indicate on the drawing exactly where your pain is at the present time.

Burning (X) Numbness (O) Pins/Needles (=) Stabbing (/) Ache (^)



Testing and Treatments

- Which of the following tests have been done for your condition?

X-ray	Date: ___/___/___	Facility _____
MRI	Date: ___/___/___	Facility _____
Cat Scan	Date: ___/___/___	Facility _____
Bone Scan	Date: ___/___/___	Facility _____
EMG	Date: ___/___/___	Facility _____
Other: _____	Date: ___/___/___	Facility _____

- Please indicate any treatments you have had for your **present** injury and their effect:

	Not Helpful	Helpful	Duration of effect:
Physical Therapy			_____
Hot Packs			_____
Ice			_____
TENS/E Stim			_____
Traction			_____
Exercises			_____
Acupuncture			_____
Massage			_____
Chiropractic			_____
Epidural Injection			_____
Facet Block			_____

Patient Name: _____

Activities of Daily Living

- Please check the level you are able to complete the following activities at the present time:
Independent Need some Assistance Unable
 - Walk
 - Dress
 - Bathe
 - Feed yourself
 - Clean your house
 - Care for your family
 - Drive
- Other limitations due to current condition? _____
- At one time, how long can you: Sit _____ Stand _____ Walk _____
- Do you use a: Straight cane Quad cane Walker Wheelchair
- Prior to your injury/illness was your ability to do things at all limited? No Yes **If yes, please explain.** _____
- Are there stairs to enter/or in your home? No Yes How many? _____ Is there a rail? Yes No

Employment Status

- Job Title/Occupation: _____
- Briefly describe your job duties: _____
- Are you currently under work restrictions No Yes **If Yes, what are your restrictions?** _____
- Please check current work status:
Working Full Time - Hours worked per day _____ Days worked per week _____ Shift _____
Working Part Time - Hours worked per day _____ Days worked per week _____ Shift _____
Working Light Duty- Hours worked per day _____ Days worked per week _____ Shift _____
Off Duty due to Injury - Date Last worked: _____
Retired/Not Working

Social History

- Married Single Separated Divorced Widowed Number of Children _____
- Do you Smoke? No Yes Packs/Day _____ How many years? _____
 Quit When? _____
- Do you drink alcoholic beverages? No Yes How much per day? _____ Per week ? _____
- Do you or have you used street drugs? No Yes What Kind? _____

Family History

Please check any diseases/disorders that run in your family. Do not include yourself.

Relative	Relative
Heart disease _____	Arthritis _____
Hypertension _____	Alcohol Abuse _____
Diabetes _____	Drug Abuse _____
Cancer _____	Other _____

Patient Name: _____

Past Medical History

Do you or have you had any problems with: (Check all that apply)

- Alcohol Abuse
- Diabetes
- HIV/AIDS
- Stroke/ TIA
- Arthritis
- Drug Abuse
- Hypertension
- Other _____
- Asthma
- Heart Disease
- Kidney Disease
- Cancer
- Hepatitis
- Liver Disease

• Please list surgeries you have had: _____ Date: _____

Review of Systems

Do you have problems with any of the following? Please check all that apply.

General

- Fatigue
- Weakness
- Trouble sleeping

Skin

- Rashes
- Dryness
- Color changes
- Hair/nail changes

Head

- Headache
- Head Injury

Eyes/Ears/Nose/Throat

- Blurry or double vision
- Eye pain
- Blindness
- Ear pain
- Ringing in ears
- Deafness
- Nose bleeds
- Dry mouth
- Sore throat/hoarseness
- Non-healing sores

Neck

- Stiffness
- Swollen glands
- Pain

Cardiac

- Palpitations
- Chest discomfort at rest
- Chest discomfort with activity

Respiratory

- Wheezing
- Shortness of breath with normal activity
- Shortness of breath with exertion
- Cough- wet, dry or productive
- Coughing up blood

Circulation

- Discoloration of feet/legs
- Sores/ulcers on feet/legs
- Swelling of ankles/legs
- Calf pain with walking
- Leg Cramps
- Varicose veins

Gastrointestinal

- Difficulty swallowing
- Heartburn
- Unexplained nausea/vomiting
- Change in bowel habits
- Constipation
- Diarrhea
- Blood in stool
- Loss of bowel control
- Abdominal pain

Genitourinary

- Frequent urination
- Painful urination
- Loss of bladder control

Musculoskeletal

- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma

Nervous System

- Dizziness
 - Fainting
 - Seizures
 - Numbness/Tingling
- Metabolism/Endocrine**
- Heat or cold intolerance
 - Excessive sweating
 - Increased thirst
 - Change in appetite
 - Recent unexplained weight changes

Hematology

- Unexplained fevers
- Ease of bruising
- Ease of bleeding

Psychiatric

- Nervousness
- Depression/Anxiety
- Memory loss
- Stress

Women Only

- Currently pregnant
- Breastfeeding
- Date of last menstrual period ____/____/____

Reviewed by: _____

Date: ____/____/____

NORTHEASTERN REHABILITATION ASSOCIATES, PC

MEDICATION TREATMENT AGREEMENT

You acknowledge that you:

- Understand that you are responsible for the medication and prescriptions used in your treatment. You must be discreet about possessing narcotics and keeping medications and prescriptions in inaccessible places so that they are not lost or stolen. Since the drugs may be hazardous to a person who is not tolerant of their effects, especially children, you must keep them out of reach of such people.
- Understand that you may not share, sell or otherwise permit others to have access to these medications.
- Understand that **all** prescriptions for controlled substances must come from your treating Northeast Rehab physician. Obtaining medications from multiple sources can lead to drug reactions and poor coordination of treatment. If, for some reason, you encounter an emergency situation and are given controlled substances by a health care professional, you agree to report the facts of this matter to your Northeast Rehab physician and you consent to the disclosure of all personal health information related to this matter.
- Agree to supply Northeast Rehab with the name and telephone number of the pharmacy that is filling your pain medication prescriptions and **you will only use one pharmacy**. Should the need arise to change pharmacies our office must be informed immediately.
- Agree to allow your Northeast Rehab physician to send a copy of this agreement to your pharmacy, referring physician and all other physicians involved in your care.
- Understand that if medication prescribed causes adverse reaction, you will stop the medication immediately and inform your Northeast Rehab physician.
- Understand there is a risk of psychological dependence on a controlled substance (narcotics). You may develop a tolerance, and become physically dependent on the medication as well. When you stop the medication you should do so slowly and under medical supervision or you may experience withdrawal symptoms.
- Agree to take the medication only and **exactly** as prescribed by your Northeast Rehab physician. You may not change your medication dosage amounts without **prior** authorization from your prescribing physician.
- Understand that it is not our practice to make changes to your prescriptions by telephone. We do not see walk-ins. You must make an appointment.
- Understand that each prescription is for a specific number of pills, designed to last a certain amount of time. **Early refills generally will not be given.**
- Agree to keep all scheduled appointments. If unable to keep an appointment, you must give the office at least 24 hours notice however; no prescriptions will be called in.
- **Agree not to seek pain medication after office hours, on the weekend, on holidays or prior to next office visit.**

- Understand that no allowance will be made for lost or stolen prescriptions or pills or those destroyed by fire, flood, etc.
- Understand that unannounced urine and/or serum toxicology screens may be requested, and your cooperation is required.
- Understand that if the responsible legal authorities have questions regarding your treatment, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.
- Understand that the physicians of Northeast Rehab may terminate and cancel any prescriptions, if any of the following occurs:
 - You give, sell, or misuse your pain medication, including but not limited to: taking more medication than prescribed, running out of medication early, obtaining medications at more than one pharmacy,
 - You fail to keep your follow- up appointments,
 - You attempt to obtain pain medication after office hours, on the weekend, on holidays, from any other physician, or any other source,
 - You are released from the practice for any reason,
 - Any allegations, suspicious information or an investigation is initiated by anyone regarding potential violations of this agreement, is brought to the attention of your Northeast Rehab physician.
- **By signing this document you acknowledge that:** You have received information from your treating Northeast Rehab physician regarding the risks and potential benefits of these medications, you have received and understand the Northeast Rehab Prescription Refill Policy, and you agree to adhere to the terms of this Medication Agreement, knowing that **failure to do may result in termination of treatment with all Northeast Rehab providers.** This agreement is in effect for the duration of your treatment.

Patient Signature _____ Date ____/____/____

Patient Name _____ Date of Birth ____/____/____
 Please Print

The pharmacy you have selected is: _____
 Pharmacy Name Phone

Reviewed by Physician/Staff Signature _____ Date ____/____/____

■ **Patient Information**

Name: _____ Date of Birth: ____ / ____ / ____
Last First Middle I.

Sex: M F Soc. Sec. # : ____ / ____ / ____

Home Phone: () _____ Cell Phone: () _____

Work Phone: () _____

Address: _____

City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone: () _____

■ **Primary Insurance**

Insurance Company: _____

Insurance ID # : _____ Group # : _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box and skip to the next section.

Policyholder's Name: _____ Date of Birth: ____ / ____ / ____
Last First Middle I.

Relationship to Patient: _____ Soc. Sec. # ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____

Employer: _____

■ **Secondary Insurance**

Insurance Company: _____

Insurance ID # : _____ Group # : _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box and skip to the next section.

Policyholder's Name: _____ Date of Birth: ____ / ____ / ____
Last First Middle I.

Relationship to Patient: _____ Soc. Sec. # ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____

Employer: _____

Please complete this section if this is a Work Related Injury or Auto Accident:

Patient Name: _____

■ **Work Related Injuries**

Date of Injury: ____ / ____ / ____ Claim #: _____

Worker Comp Insurance Carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____ Contact Name: _____

Employer: _____ County located in: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____

Contact Name: _____ Phone: () _____

■ **Auto Accident**

Date of Accident: ____ / ____ / ____ Claim #: _____

Auto Insurance Carrier: _____

Insurance ID # : _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____

Contact Name: _____ Phone: () _____

■ **Attorney Information**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____