Northeastern Rehabilitation
ASSOCIATES, P.C.

Thank you for choosing Northeastern Rehabilitation Associates

-www.nerehab.com-

To ensure we are providing quality care, we need information from you and need to provide you with information about our practice policies. Our ***New Patient Brochure*** *is enclosed and it outlines our services and practice policies. Please review prior to your visit.*

Please complete the attached ***New Patient Packet*** *in its entirely* ***prior to arriving*** *for your appointment. This information is important for your physician to review with you during your initial visit and if not completed, it may delay your appointment time.*

Many of our patients experience acute and chronic pain. NERA Physicians will work with you to create an effective treatment plan, tailored just for you. Goals of a treatment plan often include reducing pain, maximizing your ability to perform functions of daily living and to help improve your quality of life. Patient Health Questionnaires are tools used to assist in creating your treatment plan. Please complete the enclosed, ***SOAPP-14 and PHQ9 Assessment Tools*** *and bring with you to your first visit. You may be asked to update this information annually or more often as your treatment plan changes over time.*

To provide you with secure electronic access to our physicians and staff, Northeastern Rehabilitation Associates utilizes a ***Patient Portal****. Instructions for access are included in this packet. You can request appointments, update your medical history, medications, allergies, and send a note to your provider. Your provider may send forms for you to complete as part of your treatment plan via the Portal as well.*

We encourage you to sign up for the Patient Portal before your first visit.

Patient Information Sheet *(Please Print)*

Patient Name: _____
Last First Middle I

Date of Birth: _____ / _____ / _____ **Soc. Sec. # :** _____ / _____ / _____ **Sex:** ☐ M ☐ F

Race: ☐White ☐Black/African American ☐American Indian/Alaska native ☐Asian
☐Native Hawaiian/other Pacific Islander ☐Other _____

Ethnicity: ☐Not of Spanish/Hispanic descent ☐Spanish/Hispanic **Primary Language**:_____

Home #: _____ **Cell #:** _____ **Work #:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Emergency Contact_____ **Phone:** _____

Person(s) we may speak with regarding your medical/financial information should the need arise:
Name: _____ **Relation:** _____

■ **Primary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, 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 Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, 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 #:** _____

Employer: _____ **County located in:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

Address where Injury Occurred- if different than address above:

City: _____ **State:** _____ **Zip:** _____

Job Title: _____ **Usual Job Duties:** _____

■ **Auto Accident**

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

State where Injury Occurred: _____

Auto Insurance Carrier: _____

Insurance ID # : _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

■ **Attorney Information - if Applicable**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

PATIENT PAIN HISTORY:

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

1. Which is your dominant hand? ☐ Left ☐ Right ☐ Ambidextrous
2. What is your main complaint?_____
   _____
   _____
3. Is this the result of a Work Injury? ☐ No ☐ Yes **If yes**, date of injury: _____/_____/_____
   Describe this incident: _____
   _____
   _____
4. Is this the result of a Motor Vehicle Accident? ☐No ☐ Yes **If yes**, date of accident: _____/____/_____
   Describe this incident: ☐ Head-On ☐ Rear-Ended ☐ T-Boned ☐ Other_____
   _____

☐ Driver ☐ Passenger Front Seat ☐ Passenger Back Seat	☐ Loss of consciousness ☐ Airbags deployed ☐ Seatbelt	☐ Ambulance: ☐ C-Collar ☐ Backboard Name of ER: _____

5. If you answered NO to questions 3 and 4, please describe when and how your illness or injury occurred:
   _____
   _____
6. Have you had anything similar before? ☐ No ☐ Yes **If yes,** please explain:
   _____
   _____
7. Prior to this episode, were you completely symptom free? ☐Yes ☐ No **If no**, please explain:
   _____
   _____
8. What doctors have you seen for this problem?_____
   _____
9. TESTING
   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 bring any/all X-rays, MRIs, and Medical Records that may pertain to your current problem/injury.**

Patient Name: _____

10. Please review the pain scale below. Indicate by answering **0-10** which best describes your pain level:
a. Current pain level:_____ **b.** Past 30 days, pain at its best:_____ **c**. Past 30 days, pain at its worst: _____

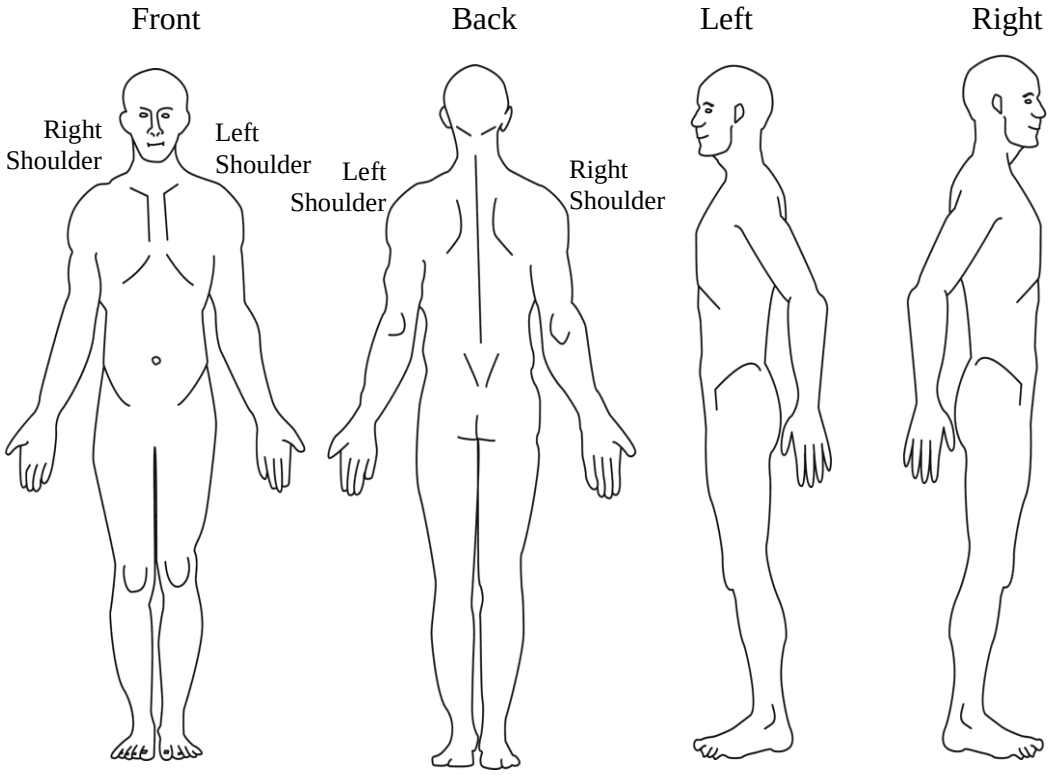
0	**No Pain**	I have no pain
1	**Minimal**	My pain is hardly noticeable
2	**Mild**	I have a low level of pain, I am aware of my pain only when I pay attention to it
3	**Uncomfortable**	My pain bothers me but I can ignore it most of the time
4	**Moderate**	I am constantly aware of my pain but I can continue with most of my activities
5	**Distracting**	I think about my pain most of the time. I cannot do some of the activities I need to do each day because of the pain.
6	**Distressing**	I think about my pain all of the time. I give up many activities because of my pain.
7	**Unmanageable**	I am in pain all the time. It keeps me from doing most activities
8	**Intense**	My pain is so severe that it is hard to think of anything else. Talking and listening are difficult.
9	**Severe**	My pain is all that I can think about. I can barely talk or move because of the pain.
10	**Unable to Move**	I am in bed and can't move due to my pain. I need someone to take me to the emergency room to get help for my pain.

11. How frequent is your pain? ☐ Constant ☐Intermittent Explain_____
12. How long does your pain last? ☐ Less than 1 hour ☐ Less than 1 day ☐All day ☐All night
13. Is your pain getting: ☐ Better ☐ Worse ☐ Not changing

	Worsens Pain	**Relieves Pain**	**No Effect on Pain**		**Worsens Pain**	**Relieves Pain**	**No Effect on Pain**
Sitting				Standing			
Rising from sitting				Driving			
Walking				Coughing/Sneezing			
Bending forward				Lying on your side			
Bending backward				Lying on your back			
Bending to the side				Lying on your stomach			

USE THE FOLLOWING SYMBOLS TO INDICATE ON THE DRAWING EXACTLY WHERE YOUR PAIN IS <u>AT THE PRESENT TIME</u>.

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



Patient Name: _____

1. Have you had any Physical Therapy in the past 2 years? ☐ No ☐ Yes
   If yes, please indicate the following:

   a. Body Part Treated: _____ Facility:_____
   When (Month/Year): _____ How Long: _____
   b. Body Part Treated: _____ Facility:_____
   When (Month/Year): _____ How Long: _____

2. Please check next to any other treatments you have had for your **present** injury:

   ☐ Ice/Heat: Helpful? Yes ☐ No ☐
   ☐ Anti-inflammatory Medications (NSAIDs) including over the counter Advil, Aleve, etc.
   When? _____ / How Long?_____ Helpful? Yes ☐ No ☐

   ☐ TENS/ E Stim: Helpful? Yes ☐ No ☐ Also, do you have a unit for home use? ☐Yes ☐ No
   ☐ Traction: Helpful? Yes ☐ No ☐ Also, do you have a unit for home use? ☐Yes ☐ No
   ☐ Exercises: Helpful? Yes ☐ No ☐
   ☐ Acupuncture: Helpful? Yes ☐ No ☐
   ☐ Massage: Helpful? Yes ☐ No ☐
   ☐ Chiropractic: Helpful? Yes ☐ No ☐
   ☐ Injections: Helpful? Yes ☐ No ☐ What type of injection?_____
   When was your last injection? _____
   ☐ Bracing: Helpful? Yes ☐ No ☐
   ☐ Psychological Treatment: Helpful? Yes ☐ No ☐

3. With respect to your pain, how are you feeling now compared to before you received treatment?

   ☐ Very Much Worse ☐ Much Worse ☐ Minimally Worse ☐ No Change
   ☐ Minimally Improved ☐ Much Improved ☐ Very Improved

PAST MEDICAL HISTORY:

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

☐ Alcohol Abuse	☐ Cholesterol	☐ Hepatitis	☐ Stroke/ TIA
☐ Arthritis (Osteoarthritis)	☐ Diabetes	☐ HIV/AIDS	☐ Thyroid
☐ Arthritis (Rheumatoid)	☐ Fibromyalgia	☐ Hypertension	☐ Anxiety
☐ Asthma	☐ GERD (Reflux)	☐ Kidney Disease	☐ Depression
☐ Cancer	☐ Heart Disease	☐ Liver Disease	
Type: _____	☐ Drug Abuse ☐ Prescription drugs ☐ Street drugs		

☐ Other: _____

☐ Past Work Injury – Date: _____ ☐ Past Motor Vehicle Accident – Date: _____

PLEASE LIST SURGERIES YOU HAVE HAD: **DATE:**

_____ _____
_____ _____
_____ _____

Patient Name: _____

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

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

SOCIAL HISTORY:

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

1. Do you Smoke? ☐ No ☐Yes If yes: Packs/Day____ How many years?_____ / ☐ Quit When?_____
2. Do you drink alcoholic beverages? ☐ No ☐Yes If yes, how much per day?_____ Per week?_____
3. Do you use or have you used street drugs? ☐ No ☐Yes
   If yes, what kind and when? _____

EMPLOYMENT STATUS:

1. Job Title/Occupation: _____
2. Briefly describe your job duties: _____
3. Are you currently under work restrictions ☐ No ☐ Yes **If Yes,** what are your restrictions?
   _____
4. 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

ACTIVITIES OF DAILY LIVING: Please check the level you are presently able to complete the following activities:

	Independent	**Need some Assistance**	**Unable**		**Independent**	**Need some Assistance**	**Unable**
Walk	☐	☐	☐	Feed yourself	☐	☐	☐
Dress	☐	☐	☐	Clean your house	☐	☐	☐
Bathe	☐	☐	☐	Care for your family	☐	☐	☐
Drive	☐	☐	☐				

1. Please list up to four things in your life that you can't do or have difficulty with because of your pain and which most dearly you want restored? These should be simple, realistic daily life improvements that other people can see most of the time.
   _____ _____
   _____ _____
2. Are there other limitations due to current condition?_____
3. At one time, how long can you: Sit _____ Stand_____ Walk_____
4. Do you use any of the following? ☐ 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: _____
5. Are there stairs to enter/or in your home? ☐ No ☐ Yes How many? ____ Is there a rail? ☐ Yes ☐ No

Patient Name:_____

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
☐Memory loss
☐Stress
☐Bipolar Disorder
☐Other psychological diagnosis _____

Women Only
☐Currently pregnant
☐Breastfeeding
☐Date of last menstrual period
____/____/_____

Reviewed By:

_____

Date: _____/_____/_____