Dear New Patient:

Welcome to Physical Medicine Institute. Please take a moment to familiarize yourself with our practice guidelines.

Prior to being seen for a consultation at our office you need to include all relevant medical history and information, as this will be used to help us create your unique treatment plan.

If you do not complete all forms provided and sign where required, your appointment may be re-scheduled.

It is also very important for you to bring the report and films of your most recent MRI, CT scan, X-rays and other relevant study with you.

You have to bring the bottle(s) of all current medication(s) including if you are taking pain medications, even if the bottle(s) are empty.

We also need to have any prior medical records related to the previous treatment. Be prepared to provide information related to prior treating physicians or providers.

Please be aware that your first visit is only an evaluation and that controlled substances including opioid analgesics will not be prescribed.

The physicians at Physical Medicine Institute believe in comprehensive pain management, which may include any of the following:

- Referral to physical therapy or other interventions
- Interventional pain management or other physicians
- Mental health evaluation by a psychologist and/or psychiatrist
- Random urine/oral fluid drug testing

The patient is expected to actively participate in the comprehensive pain management program and comply with the plan of care and treatment agreement.

Thanks for choosing Physical Medicine Institute to meet your medical needs.

Sincerely,

The Staff and Physicians at Physical Medicine Institute

Patient Signature__________________________________ Date___/___/_____

WEB PORTAL

Please provide your Email ____________________@_____________

You will receive an Email with a *link*, *username* and *password* to access our web portal where you can see your health information.

Click on the *link* and use the *username* and *password* to access.

Verify your health information is accurate.

When accessing send us a message to check web portal communication is working.

PHYSMEDI

PHYSICAL MEDICINE INSTITUTE

REGISTRATION FORM

Primary Physician/Doctor Primario:	Phone Office/Teléfono Oficina:
Referring Physician/Médico de Referencia:	Phone Office/Teléfono Oficina:
Preferred Pharmacy/Farmacia de Preferencia:	Phone/Teléfono:

PATIENT INFORMATION / INFORMACION DEL PACIENTE

Patient Name/Nombre del Paciente :	Social Security Number/Seguro Social: [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]	D.O.B./Fecha Nacimiento / / Gender/Sexo M ( ) F ( )

Mailing address/ Dirección postal		City/Ciudad	State/Estado	Zip code/Código Postal

Home Phone no./Teléfono Residencial:	Cell Phone no/Teléfono Celular:	E-mail/Correo Electrónico:
Occupation/Ocupación:	Employer/Empleador:	Employer Phone Number/Teléfono Empleador:

Marital Status/Estado Civil: ( ) Single/Soltero ( ) Married/Casado ( ) Divorced/Divorciado ( ) Widow/Viudo ( ) Other/Otro

Race/Raza: ( ) Hispanic/Hispano ( ) White/Blanco ( ) African-American/Afro-Americano ( ) Asian/Asiático ( ) American-Indian/Indio-Americano ( ) Other/Otro

Ethnicity/Etnia: ( ) Hispanic or Latino/Hispano o Latino ( ) **Not** Hispanic or Latino/**No** Hispano o Latino

Languages/Idioma: ( ) English/Inglés ( ) Spanish/Español ( ) English & Spanish/Inglés y Español ( ) Other/Otro

IN CASE OF EMERGENCY / CONTACTO DE EMERGENCIA

Name of local friend or relative/Nombre de amigo o pariente(Que no viva con usted):	Relationship/Parentezco:	Home phone/Tel.Residencial:	Cell phone/ Teléfono Celular:

HEALTH INSURANCE / SEGURO MEDICO

(Please give your insurance card to the receptionist /Favor de proveer la tarjeta del seguro médico a la recepcionista.)

Primary Insurance/Seguro Primario	Policy No./Número de Póliza	Group No./Número de Grupo

Policy Holder/Propietario de Póliza:	D.O.B./Fecha Nacimiento:	S.S.N./Número Seguro Social:	Home Phone no./Teléfono Residencial:

Patient's relationship to subscriber/Relación del paciente con el dueño de póliza: ( ) Self/Propio ( ) Spouse Esposo ( ) Child/Hijo ( ) Other/Otro

Secondary Insurance/Seguro Secundario:	Policy No./Número de Póliza	Group No./Número de Grupo

Patient's relationship to subscriber/Relación del paciente con el dueño de póliza: ( ) Self/Propio ( ) Spouse/Esposo ( ) Child/Hijo ( ) Other/Otro

SELECT IF THIS APPLY: ( ) AUTO INSURANCE ( ) WORKER'S COMPENSATION

Insurance Name/Nombre del Seguro:	Date Accident/Fecha de Accidente:	Policy No./Número de Póliza:	Claim No. Número de Reclamo:

Ins. Address/Dirección del Seguro:	Phone/Teléfono:	Fax:
Case Manager/ Asesor del Caso:	Phone/Teléfono:	Fax:
Lawyer Name/Nombre del Abogado:	Phone /Teléfono:	Fax:

The above information is true to the best of my knowledge. I authorize my insurance benefits to pay directly to the physician. I understand that I am financially responsible for any balance. I also authorize PHYSICAL MEDICINE INSTITUTE or insurance company to release any information required to process my claims./ La información anterior es verdadera bajo el mejor de mis conocimientos. Autorizo a mi compañía de seguro a pagar directamente al médico. Entiendo que soy financieramente responsable de cualquier balance no cubierto. También autorizo a PHYSICAL MEDICINE INSTITUTE y/o compañía de seguros para liberar toda la información necesaria para procesar mis reclamos.

Patient/Guardian signature/Firma: ______________________ Date/Fecha: ____________

PHYSICAL MEDICINE INSTITUTE

NEW OUTPATIENT HEALTH INFORMATION SHEET

Name/Nombre: Date/Fecha: / /

FOR OFFICE USE/

Height: ________________

Weight: ________________

BP: ________________

Pulse: ________________

Record #:

SURGERIES OR OPERATIONS/cirugías: No ☐ Yes/Si ☐ If **yes/si** explain/**explique**:

____

____

PERSONAL MEDICAL HISTORY
Historial Médico Personal

	YES	NO
Diabetes Mellitus	☐	☐
Thyroid Disease/tiroide	☐	☐
Arthritis/artritis	☐	☐
Heart Disease/corazón	☐	☐
High Blood Pressure Presión alta	☐	☐
Vascular Disease Enfermedad vascular	☐	☐
Cancer/cáncer	☐	☐
Ulcers/úlceras estomacales	☐	☐
On Blood Thinner En anticoagulante	☐	☐
Pacemaker/marcapaso	☐	☐
Liver Disease/hígado	☐	☐
Kidney Disease/riñón	☐	☐
HIV/AIDS/SIDA	☐	☐
Stroke/infarto cerebral	☐	☐
Polio/poliomielitis	☐	☐
Lung Disease/pulmón	☐	☐
Other, explain:		

FAMILY MEDICAL HISTORY
Historial Médico Familiar

	YES	NO
Diabetes Mellitus	☐	☐
High Blood Pressure Alta presión	☐	☐
Heart Disease/corazón	☐	☐
Stroke/infarto cerebral	☐	☐
Cerebral/Brain Disease Enfermedad cerebral	☐	☐
Arthritis/artritis	☐	☐
Kidney Disease/riñón	☐	☐
Liver Disease/hígado	☐	☐
Lung Disease/pulmón	☐	☐
Thyroid Disease/tiroide	☐	☐
Cancer/cáncer	☐	☐
Other, explain:		

YOUR HABITS/HABITOS

Smoking/Fumar: ☐ Yes ☐ No ☐ Quit
If Yes How Much: ____________________

If QUIT When: ____________________

Drinking/Alcohol: ☐ Yes ☐ No ☐ Quit
If Yes How Much: ____________________

If QUIT When: ____________________

Street Drugs/Drogas: ☐ Yes ☐ No ☐ Quit
If Yes How Much: ____________________

If QUIT When: ____________________

ALLERGIES/ALERGIAS: No ☐ Yes/Si ☐ If **Yes/Si** explain/explique: ____________

____

REVIEW OF SYSTEM / REPASO POR SISTEMA (Please mark all that apply to you/Marcar todos los que apliquen)

FEVER/fiebre ☐
CHILLS/escalofríos ☐
WEIGHT GAIN/aumento de peso ☐
WEIGHT LOSS/pérdida de peso ☐
RASHES/erupciones ☐
BLURRED VISION / REDNESS/visión borrosa ☐
HEARING LOSS/pérdida audición ☐
NASAL STUFFINESS/congestión nasal ☐
NIPPLE DISCHARGE/secreción por pezón ☐
COUGH/toz ☐
SPUTUM/esputo ☐
SHORTNESS OF BREATH/corto de respiración ☐
CHEST PAIN/dolor de pecho ☐
PALPITATIONS/palpitaciones ☐
CALF PAIN WHEN WALKING/dolor pantorrilla ☐
LEG CRAMPS/calambre en piernas ☐

BRUISE EASILY/moretones fáciles ☐
JOINT PAIN/dolor articulaciones ☐
JOINT SWELLING/ hinchazón ☐
JOINT STIFFNESS/rigidez ☐
NECK PAIN/dolor cuello ☐
BACK PAIN/dolor espalda ☐
MUSCLE CRAMPS/musculares ☐
HEADACHES/dolor de cabeza ☐
SEIZURES/ataques epilépticos ☐
MEMORY LOSS/pérdida memoria ☐
WEAKNESS/debilidad ☐
ANXIETY/ansiedad ☐
DEPRESSION/depresión ☐
DECREASED SLEEP/pérdida sueño ☐
NAUSEA/náusea ☐
VOMITING/vómitos ☐

BLOOD IN STOOL/sangre en heces fecales ☐
DIARRHEA/diarrea ☐
STOMACH PAIN/dolor de estómago ☐
DIFFICULTY SWALLOWING/dificultad al tragar ☐
NIGHT SWEATS, HEAT OR COLD/sudoración ☐
PAIN WHEN URINATING/dolor al orinar ☐
DISCHARGE FROM GENITALIA ☐ /secreción por genitales

OTHER/OTROS, PLEASE EXPLAIN:

____

____

____

WHAT IS THE REASON OF YOUR VISIT TODAY?/ CUAL ES LA RAZON DE SU VISITA EN EL DIA DE HOY?

The present condition(s) is/are related to an accident or injury?/Su condición actual está relacionada a un accidente o lesión? ☐ Yes/Si☐ No ☐ N/A If **yes/s**i, ☐ auto ☐ work/trabajo ☐other/otro, explain: ______________________________
____ **Date of injury**/Fecha accidente_____/_____/________

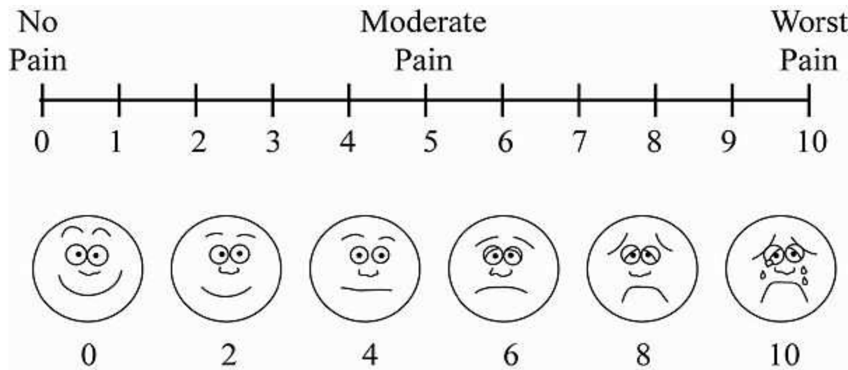
ARE YOU/ES USTED … ☐ RIGHT HANDED/DERECHO☐LEFT HANDED/ZURDO ☐AMBIDEXTROUS/AMBIDEXTRO

SYMPTOM(S) **CHARACTERISTICS**/SINTOMA:☐GRADUAL aumento ☐SUDDEN repentino / ☐CONTINUOUS continuo ☐INTERMITTENT intermitente

TREND OF SYMPTOM(S)/TENDENCIA:☐INCREASING aumentando ☐DECREASING disminuyendo ☐REMAIN ABOUT THE SAME permanence igual

PAIN QUALITY/CALIDAD DEL DOLOR	YES	NO
ACHING/molestia	☐	☐
BURNING/quemazón	☐	☐
DULL/no tan fuerte	☐	☐
PRESSURE LIKE/presión	☐	☐
SHARP/punzadas	☐	☐
STABBING/puñaladas	☐	☐
THROBBING/palpitaciones	☐	☐
TOOTHACHE LIKE/parecido dolor de muela	☐	☐

ASSOCIATED SYMPTOMS/SINTOMAS ASOCIADOS	YES	NO
ERECTILE DIFFICULTIES/disfunción eréctil	☐	☐
PROBLEMS URINATING/problema al orinar	☐	☐
PROBLEMS WITH BOWEL FUNCTION/problemas con su función intestinal	☐	☐
SYMPTOMS AT NIGHT/síntomas en la noche	☐	☐
TINGLING/hormigueo	☐	☐
WEAKNESS/debilidad	☐	☐
NUMBNESS/adormecimiento	☐	☐



WHAT MAKES THE PAIN **WORSE**?
- ☐ BENDING/doblarse
- ☐COUGHING/toser
- ☐DRIVING/conducir
- ☐LAYING DOWN/acostarse
- ☐LIFTING/levantar algo
- ☐SITTING/sentarse
- ☐STANDING/estar de pie
- ☐TWISTING/torcerse
- ☐WALKING/caminar

Choose the face that shows how bad your pain is right NOW. Then score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so '0' = 'no pain' and '10' = 'worst pain'./selecione el nivel de su dolor.	**Where is the worst pain located today?** Donde está localizado su peor dolor hoy?

- WHAT MAKES THE PAIN **BETTER?** /Que le alivia el dolor? ____
- YOUR CONDITION WAS **PREVIOUSLY TREATED** BY WHOM? /Quién trataba su condición anteriormente?
____

WHAT **TREATMENTS** HAVE YOU TRIED BEFORE? /Qué tratamientos usted ha intentado anteriormente?	WHAT PREVIOUS **TESTS/STUDIES** HAVE YOU HAD FOR THIS CONDITION?/exámenes o estudios previos
☐ CHIROPRACTIC CARE/cuidado quiropráctico	☐ ELECTRODIAGNOSTIC STUDIES (EMG & NCS) /estudios electo-diagnósticos-conducción nerviosa
☐ BRACES/soportes ortopédicos	☐ BONE SCAN/escintigrafía de hueso
☐ ACUPUNCTURE/acupuntura	☐ BONE DENSITY/densidad ósea
☐ MEDICATIONS/medicamentos	☐ MYELOGRAM/mielograma
☐ SURGERY/operaciones___________________________	☐ ARTHROGRAM/artrograma
☐ INJECTIONS/inyecciones_________________________ ____	☐ MRI/resonancia magnética
☐ PHYSICAL THERAPY/terapia física	☐ X-RAY/rayos-X
☐ ELECTRICAL STIMULATION/estimulación eléctrica	☐ CT SCAN/tomografía computarizada/CAT Scan
☐ OTHER/otro___________________________________	☐ OTHER/otro ______________________________

- LIST **CURRENT MEDICATIONS** INCLUDING OVER THE COUNTER/lista de medicamentos actuales incluyendo genéricos : ____
____
____

- LIST OTHER **MEDICATIONS** THAT YOU HAVE **TRIED IN THE PAST** FOR THIS CONDITION/ lista de medicamentos que ha intentado en el pasado para esta condición:____
____

Are you: ☐Married/casado ☐Single/soltero ☐Divorced/divorciado ☐Separated/separado ☐Widow/viudo

Do you have **hobbies**?/tiene usted pasatiempos? ☐Yes/Si ☐No If **Yes/Si**, describe/describa:__________________

OCCUPATIONAL HISTORY/HISTORIAL OCUPACIONAL:
WHAT IS YOUR OCCUPATION? /Cuál es su ocupación?____
ARE YOU STILL WORKING? /Todavía trabaja? ☐YES/Si ☐NO
HOW MANY HOURS PER WEEK?/Cuántas horas por semana?_______________________________________
LAST DAY OF WORK? /Cuando fue su último día de trabajo?_______________________________
IF YOU ARE WORKING DO YOU HAVE RESTRICTIONS?/Si todavía trabaja, tiene restricciones? ☐YES/Si ☐NO
IF **YES/Si** EXPLAIN/explique: ____
EDUCATIONAL LEVEL OR TRAINING/Nivel o formación educativa?: ___________________________________

DO YOU RECEIVE A **DISABILITY** CHECK?/Recibe cheque por incapacidad? ☐ YES/Si ☐ NO
DO YOU RECEIVE A **WORKERS COMP** CHECK?/Recibe cheque por workers comp? ☐ YES/Si ☐ NO
DO YOU **HAVE SELF CARE OR MOBILITY ISSUES**?/Problemas con cuidado propio o movilidad ☐ YES/Si ☐ NO
FOR FEMALES ONLY, ARE YOU PREGNANT?/Está usted embarazada? ☐ YES/Si ☐ NO ☐ N/A IF **YES/**Si**,** HOW MANY WEEKS OF PREGNANCY? /Cuántas semanas de embarazo? _________________ WHAT IS THE EXPECTED DELIVERY DATE? /Cuando es la fecha esperada para parto?____
DO YOU HAVE AN **ATTORNEY** FOR PRESENT CONDITION(S)?/Tiene usted un abogado para su condición actual?
☐ YES/Si ☐ NO IF **YES/Si**, THIS IS FOR AUTO-RELATED/accidente de carro ☐ WORK-RELATED/relacionado al trabajo ☐ OTHER/otro ☐ EXPLAIN/explique____
NAME OF ATTORNEY/Nombre del abogado____
BENEFITS EXHAUSTED?/Beneficios agotados? ☐ YES/Si ☐ NO ☐ N/A
CASE SETTLED?/Caso concluído? ☐ YES/Si ☐ NO ☐ N/A

____ ________________________
Patient Signature/Firma de Paciente Date/Fecha