

ADVANTAGE PHYSICAL MEDICINE AND REHABILITATION, LLC

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New Patient Registration Form

(please print)

Demographics

Name (first, last): _____ Date: ____/____/____

Date of Birth: ____/____/____ Social Security #: _____ - _____ - _____ Sex: Male Female

Mailing Address: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____ - _____

Home Phone: _____ Work Phone: _____ ext. _____

Cell Phone: _____ Other: _____

Preferred Contact Number: Home Cell Work Other

Emergency Contact: _____ Relationship: _____

Phone: _____ Home Cell Work

Referred to our office by: Physician _____ Hospital/Facility _____

Patient/Family/Friend Attorney _____ Other: _____

Primary Care Physician: _____

Referring Physician: _____

Pharmacy Name & Address: _____

Pharmacy Phone Number: _____

Race:

White American Indian/Alaska Native Asian Other

Black/African American Native Hawaiian/Other Pacific Islander Patient Declined/Unknown

Ethnicity: Spanish/Hispanic Not of Hispanic Origin

Primary Language: _____ Country: _____

Name (first, last): _____

Date: ____/____/____

Medical Insurance Information (provide card and/or referral)

Primary Insurance Company: _____

ID #: _____ Relationship to Insured: Self Spouse Child Other

Policy Holder's Name: _____ DOB: ____/____/____

Policy Holder's Employer: _____

Secondary Coverage (if applicable):

Insurance Company Name: _____ ID #: _____

Policy Holder's Name: _____ DOB: ____/____/____

Yes No today's visit, is a **motor vehicle accident** related injury.

- If **Yes**, please complete **NYS No-Fault Verification of Treatment Form ("NF-3")**.
- If **No**, proceed to **Medical History** section.

Yes No today's visit, is a **work-related** injury.

- If **Yes**, please complete **Workers' Compensation** section.
- If **No**, proceed to **Medical History** section.

Name (first, last): _____

Date: ____/____/____

Medical History

1. Past Medical History: Do you now or have you ever had?

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other medical conditions (*please list*):

2. List all surgeries' dates with reasons and any hospital admissions related to today's visit:

3. List all prescription medications with dose (*include strength & number of pills per day*) and frequency (*how often you take them*) (*i.e. Advil 200 mg, 1 tablet by mouth 2x a day*)

4. Medication/Drug/Food allergies (*please include: IV Dye, CT Contrast, shellfish, etc.*): No Yes, to what?:

Name (first, last): _____

Date: ____/____/____

5. Family History: list all medical problems in your immediate family (*i.e. diabetes, arthritis, cancer, etc.*):

6. Currently Working? Yes No

a. If Yes: Light Duty Full Duty

i. What is your occupation? _____

b. If Retired, what was your prior occupation? _____

7. Do you smoke cigarettes? Yes No

c. If yes, how many cigarettes or packs per day? _____

8. Have you stopped smoking? Yes No

d. If so, when? _____

9. Do you drink alcohol? Yes No

e. If yes, how many drinks per day? _____

10. Other drug use? Yes No

f. If yes, what drug and how much? _____

Symptoms Checklist

Symptoms	Please Circle	
Fever or night sweats	Yes	No
Chest pain	Yes	No
Shortness of breath	Yes	No
Loss of bowel control	Yes	No
Loss of bladder control	Yes	No
Inflammatory arthritis	Yes	No
Skin rashes	Yes	No
Weakness	Yes	No
Depressed mood	Yes	No
Difficulty sleeping	Yes	No
Diabetes or thyroid disease	Yes	No

Name (first, last): _____

Date: ____/____/____

Pain Diagram

1. Where is your pain? Where is your numbness/tingling?

Please mark on the diagrams:Pain = **X**Numbness/tingling = **O**Both = **⊗**

2. Was there an injury? If yes, what was the date of injury?
3. How long have you had your pain?
4. Please describe the quality of your pain.
(*sharp, dull, stabbing, ache, throb or other*)
5. Please rate your current pain level from 0 to 10.
6. Does your pain radiate or travel?
7. Is your pain constant or does it come and go?
8. What makes the pain worse? (*bending, lifting, sitting, standing, walking or other*)
9. What makes the pain better? (*medications, rest, therapy, ice, heat, or other*)
10. Do you have any numbness or tingling?

