New Patient Intake Form

Name _____ Date _____
DOB ____/____/____ Age____ Sex: ☐M ☐F
Height_____ Weight_____ Handedness: ☐ R ☐L
Who referred you here? _____
Who is your PCP? _____

HISTORY OF CURRENT PROBLEM

Date your current problem began? _____
Did you ever have this problem before? ☐ Yes ☐ No
If yes, when? _____
Is your problem the result of a (n)...?
☐ Auto Accident ☐ Injury on the job
☐ Recreational Injury ☐ No known cause
☐ Other _____
Describe the original injury if known: _____
_____
Who has treated you for this problem?
Dr. _____ City: _____
Dr. _____ City: _____

TESTS you have had for this problem:
☐ X-Ray ☐ CT scan ☐ MRI ☐ EMG ☐ Other
Date(s) of test(s): _____
Where done: _____

TREATMENTS you have tried for this problem:

☐ Physical Therapy	☐ Acupuncture
☐ Chiropractor	☐ Injections/Nerve blocks
☐ Home exercises	☐ Psychological counseling
☐ TENS Unit	☐ Massage
☐ Braces	☐ Ice/heat
☐ Other _____	

Have you had SURGERY for this? ☐ Yes ☐ No
Date and name of surgery: _____
_____

MEDICATION you have tried for this problem:

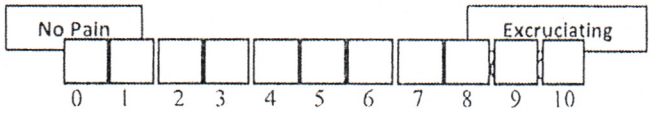
☐ Aspirin	☐ Ibuprofen (Advil/Motrin)	☐ Naproxen(Aleve)
☐ Tylenol	☐ Celebrex	☐ Diclofenac
☐ Cymbalta	☐ Prozac	☐ Trazodone
☐ Neurontin (Gabapentin)	☐ Nortriptyline (Pamelor)	☐ Amitriptyline (Elavil)
☐ Ultram	☐ Muscle Relaxers (Flexeril/Skelaxin/Soma)	☐ Lyrica

Narcotic Name(s) _____
Other meds tried: _____

CURRENT PROBLEM:

How would you describe you problem?
☐ Constant ☐ Occasional but goes away
☐ Frequent but goes away ☐ Rare
Is your problem worse in the...
☐ Morning ☐ Evening ☐ Nighttime
What makes your problem worse?
☐ sitting ☐ standing ☐ walking
☐ other _____
_____
What makes your problem better?
☐ sitting ☐ standing ☐ walking
☐ other _____

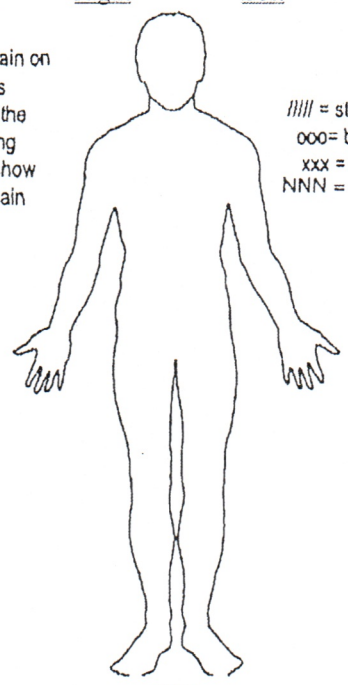
AVERAGE PAIN INTENSITY: Fill in bubble below:



Right Left

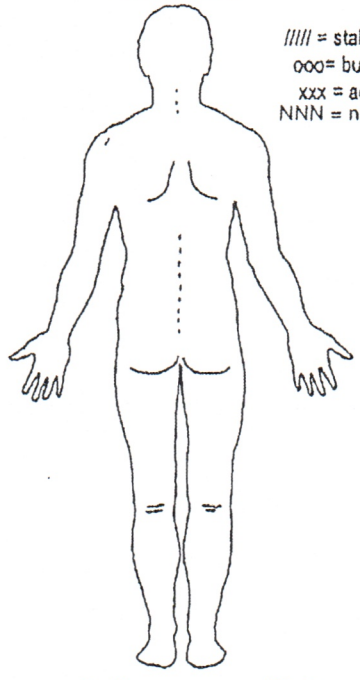
Front

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



//// = stabbing pain
ooo= burning pain
xxx = aching pain
NNN = numbness

Back



//// = stabbing pain
ooo= burning pain
xxx = aching pain
NNN = numbness

Left Right

Reviewed by: _____ On Date: _____

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Do you have...

Fevers or chills (unexplained)	☐ Yes	☐ No
Weight loss (unexplained)	☐ Yes	☐ No
Incontinence (leak urine or stool)	☐ Yes	☐ No
Numbness in arms or legs	☐ Yes	☐ No
Weakness in arms or legs	☐ Yes	☐ No
Sleep problems	☐ Yes	☐ No
Do you have an attorney for this issue?	☐ Yes	☐ No

How long can you sit? _____

How long can you stand? _____

How far can you walk? _____

What can you NOT do because of this problem?

_____

OTHER MEDICAL PROBLEMS:

Do you have or have you ever had in the past any of the following medical problems?

- ☐ Eye problems
- ☐ Anemia/bleeding problems
- ☐ AIDS/HIV
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Lung problems
- ☐ Heart disease
- ☐ Aspirin sensitivity
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Polio
- ☐ Psoriasis
- ☐ Cancer
- ☐ Stroke
- ☐ Seizures
- ☐ Migraines
- ☐ Nerve problems
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Rheumatic fever

Other: _____

Are you currently experiencing any of the following conditions?

- ☐ Difficulty swallowing
- ☐ Leg swelling
- ☐ Cough
- ☐ Shortness of breath
- ☐ Eye pain
- ☐ Chest pain
- ☐ Palpitations
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive urination or thirst
- ☐ Easy bruising/bleeding
- ☐ Rash
- ☐ Joint swelling
- ☐ Immunocompromised
- ☐ Balance problems
- ☐ Feeling "down"

ANY PAST: Name type and date (month/yr), if known.

SURGERIES: _____

_____

CAR ACCIDENTS: _____

WORK INJURIES: _____

SOCIAL HISTORY: Do you currently ...

Smoke?	☐ Yes, How much? _____	☐ No
Drink alcohol?	☐ Yes, How much? _____	☐ No
Drink caffeine:	☐ Yes, How much? _____	☐ No
Use recreational drugs:	☐ Yes, What kind? _____	☐ No

Marital status: ☐ S ☐ M ☐ D ☐ W ☐ SO

Do you have any children: ☐ Yes - Ages: _____ ☐ No

Who lives with you? _____

List your hobbies? _____

What do you do for exercise, and how often do you exercise?

_____

Highest level of education:

_____

WORK HISTORY:

Which of the following best describes you currently?

☐ Currently working:

- Occupation: _____
- Employer: _____
- How long working there? _____
- Any current work restrictions? _____
- Past Jobs: _____

☐ Not working because of this problem:

- Date last worked? _____
- How long working there until your injury? _____

☐ Not working due to another health problem:

- Describe _____

☐ Unemployed ☐ Student ☐ Homemaker

☐ Retired: When _____ Occupation _____

AVERAGE DAILY STRESS LEVEL:

☐ None ☐ Mild ☐ Moderate ☐ Extreme

FAMILY HISTORY:

Have any of your parents (or close relatives) had...

- ☐ Neck or back problems
- ☐ Other muscle or bone or nerve problems
- ☐ Bleeding problems
- ☐ Cancer – Describe: _____
- ☐ Disability from work
- ☐ Diabetes

Other _____

MEDICATION ALLERGIES: Attach additional sheets if necessary.

DRUG	REACTION

CURRENT MEDICATIONS, vitamins, herbs

List every thing you take daily or as needed.

Attach additional sheets if necessary.

NAME	DOSE	FREQUENCY

PHARMACY (Name and Phone):

_____

_____

List any other concerns you have: _____

_____

What do you hope we can accomplish in today's visit? _____

_____

_____

Reviewed by: _____ On Date: _____

Michelle L Pepper, MD

PATIENT INFORMATION:

Patient Name	Marital Status	Gender	Date of Birth	Cell Phone
Current Address	City	State	Zip	Home Phone
Employer	Address			Work Phone
Social Security Number	Email Address			
Spouse's Name (if married)	Spouse's Date of Birth			Spouse's Daytime Phone

RESPONSIBLE PARTY INFORMATION:

Name		Gender		Date of Birth
Mailing Address	City	State	Zip	Home Phone
Employer	Address			Work Phone
Relationship to Patient				

EMERGENCY CONTACT:

Name	Relationship	Daytime Phone Number

In an attempt to conserve the environment, we are trying send to all correspondence electronically.
Please tell us how you would like to receive that communication:
Appointment reminders:

- ◯ Text to cell phone listed above
- ◯ Email to address listed above
- ◯ Phone call to home phone number listed above

Statements:

- ◯ Email
- ◯ Text
- ◯ Mail (a $2 processing fee will apply for each mailed statement)

Michelle L. Pepper, MD

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your healthcare provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider.

1. Each patient is responsible for his or her own bill.
2. Payment of all insurance co-payments and deductibles is required at the time medical services are rendered. A billing fee of $10 will be charged if you are unable to pay required co-payments on the day of service.
3. Patients who have no insurance are required to pay 100% of the cost of services rendered at each visit. If this is impossible you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. You may be eligible for a 15% discount if you do not have medical insurance and pay your bill in full on the day of service. We accept cash, check and major credit cards.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.
6. If your insurance company has not paid your full account within 60 days, you must pay the outstanding balance without further delay.
7. Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1 ¾% per month (21% annual rate) will be charged to the amount not paid after 60 days, with a minimum charge of $.50 per month. By signing below, you agree to pay collection costs up to 50% with or without suit and/or reasonable attorney's fees on any delinquent balance, if referred to any agency or attorney for collection or suit.
8. A $25.00 fee will be charged on all returned checks.
9. Patients who fail to appear for their scheduled appointments may be charged a fee of $50.00, unless the patient cancels the appointment at least 24 hours before the scheduled appointment time.

USUAL AND CUSTOMARY RATES: Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your insurance, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any).

AUTHORIZATION TO PAY BENEFITS: I further authorize and direct said agency, attorney or Insurance Company to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

_____ _____

Signature of Patient or Responsible Party *Date*

_____ _____

Printed Name *Date of Birth*

Michelle L. Pepper, MD
Physical Medicine and Rehabilitation
6112 South 1550 East, Ste 202
Ogden, UT 84405
Phone: 385-432-3240 Fax: (716) 333-8513

HIPAA ACKNOWLEDGEMENT

I hereby acknowledge that I have had the opportunity to review and/or receive a copy of HIPAA Notice of Privacy Practices for Michelle L Pepper, MD.

AUTHORIZATION

My signature below authorizes the staff of Michelle L. Pepper, MD to verbally (by telephone or in person) share all of my medical information without limitation with the following individuals:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Print Name:_____Date of Birth:_____

Signature:_____Date:_____

This form does not entitle these persons to copies of medical records. Consent expires with the end of my care with Michelle L. Pepper, MD