



# Health Questionnaire

First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Male / Female

Email address: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

How did you hear about the office? \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation: \_\_\_\_\_ Type of Tasks Performed / Movements: \_\_\_\_\_

Full Time FL Resident:  YES  NO: ALTERNATE RESIDING STATE: \_\_\_\_\_ Dates of Residency- From: \_\_\_\_\_ To: \_\_\_\_\_

ALTERNATE ADDRESS: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # \_\_\_\_\_  C  W  H Primary Care Physician: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor Spouse's Name: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

**CHECK OFF ALL THE ITEMS YOU ARE CURRENTLY HAVING DISCOMFORT WITH:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Back Pain(Mid/Low)  | <input type="checkbox"/> Tension across Top of Shoulders | <input type="checkbox"/> Hip Pain                           |
| <input type="checkbox"/> Neuropathy          | <input type="checkbox"/> Shoulder Pain                   | <input type="checkbox"/> Knee Pain/Arthritis                |
| <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Numbness/Tingling in Arms/Hands | <input type="checkbox"/> Tired/Fatigued/Difficulty Sleeping |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Numbness/Tingling in Legs/Feet  | <input type="checkbox"/> Allergies                          |
| <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Pain in the Legs/Feet           | <input type="checkbox"/> Digestiv e Problems                |
|  |  | <input type="checkbox"/> Carpal Tunnel                      |

OTHER (explain) \_\_\_\_\_

Which of the above is **the worst**? \_\_\_\_\_ **How long** have you had it? \_\_\_\_\_

**How often** does it occur? \_\_\_\_\_ What does it feel like?(describe) \_\_\_\_\_

What have you done that has helped this problem? \_\_\_\_\_

**WHAT ACTIVITIES WOULD YOU LIKE TO DO IF THIS WAS NOT A PROBLEM?** \_\_\_\_\_

**DOES THIS CAUSE YOU TO BE:**

- Moody
- Irritable
- Interrupt sleep
- Restricted in your daily activities

**DOES THIS AFFECT YOUR:**

- Decision making
- Poor attitude
- Decreased productivity
- Exhausted at the end of the day
- Unable to work long hours

**DOES THIS AFFECT YOUR LIFE:**

- Lose patience with spouse/children
- Restricted household duties
- Hinders ability to exercise or sports
- Interferes with ability to do hobbies or other activities

**WHAT HAVE YOU TRIED TO HELP RELIEVE / GET RID OF THIS PROBLEM AND HOW MUCH DID IT HELP? ( circle)**

- |  |  |
|--|--|
| ◆ Medications... Helped: Little Some Much      | ◆ Exercise... Helped: Little Some Much   |
| ◆ Physical Therapy... Helped: Little Some Much | ◆ Nutrition... Helped: Little Some Much  |
| ◆ Chiropractic... Helped: Little Some Much     | ◆ Stretching... Helped: Little Some Much |

OTHER \_\_\_\_\_

Have you had **ANY ACCIDENTS WITHIN THE PAST YEAR** that affected your symptoms?  Auto  Slip/Fall  Other  NONE

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT INFORMATION**

 Preferred Method of communication for reminders:  Email  Phone  Mail

 Race:  American Indian  Alaska Native  Asian  African American  White (Caucasian)  
 Native Hawaiian  Pacific Islander  Other  I Decline to Answer

 Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  I Decline to Answer

 Smoking Status:  Every Day Smoker  Occasional Smoker  Former Smoker  Never Smoked

 What is your intake of the following: **Caffeine** \_\_\_\_\_ cups per day **Alcohol** \_\_\_\_\_ drinks per week

*I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of care.)*
**PATIENT SIGNATURE:** \_\_\_\_\_ Preferred Language: \_\_\_\_\_

**ACCIDENTS**

 Have you had an auto accident? (X if applies):  0-6mo  6 mo-1 yr  1-3yrs  3+yrs  Never

 Had a recent fall/other accident? (X if applies):  0-6mo  6 mo-1 yr  1-3yrs  3+yrs  Never

 Have you ever received Pain Management, Physical Therapy, or Chiropractic Care?  Yes  No  
 Last Visit? \_\_\_\_\_

**MEDICATIONS/ALLERGIES**

 Are you currently taking any **MEDICATIONS**?  Yes  No **If YES, complete below or attach medication list.**

MEDICATION NAME	Dosage & Frequency (i.e. 5mg once a day, etc.)

 Do you have any **ALLERGIES**?  Yes  No (Please place a check mark next to any known allergy that you have.)

 Milk  Eggs  Peanuts  Almonds  Cashews  Walnuts  Fish  Shellfish  Soy  Wheat  
 Gluten  Penicillin  Sulfa Drugs  Tetracycline  Codeine  NSAIDS  Phenytoin  Latex  
 Carbamazepine  Mildew  Mold  Dust  Fungus  Mites  Tree Pollen  Grass Pollen  
 Weed Pollen  Insects  Dog Dander  Cat Dander  Other Animal Dander  Chicken/Eggs  
 OTHER: \_\_\_\_\_ (please fill in)

 Describe Reaction and Onset(s): \_\_\_\_\_

**INSURANCE**

 Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_

 Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**
**Assignment and Release (insured patients)**

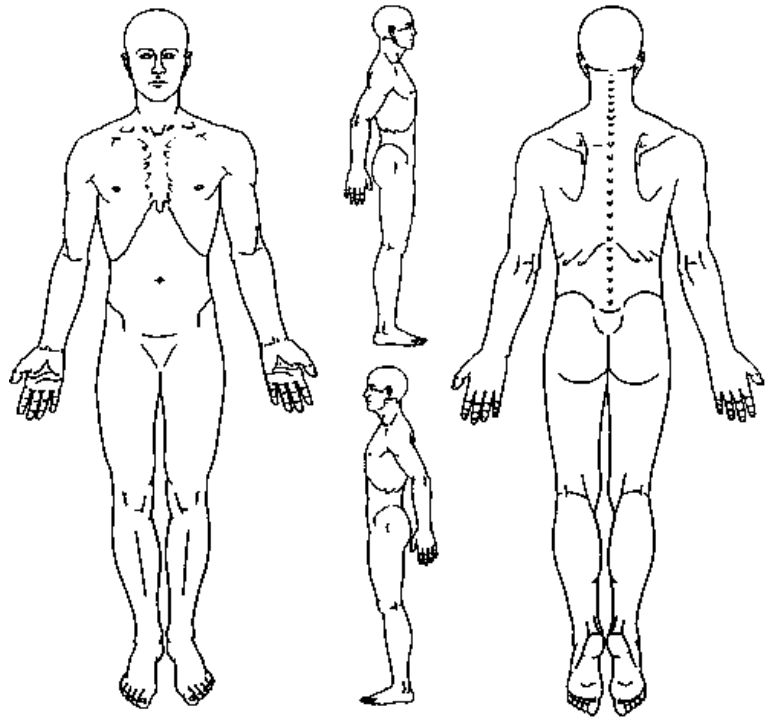
I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Platinum Healthcare Physical Medicine, LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

# PATIENT HEALTH HISTORY

Please **CHECK** to indicate if you are currently experiencing any of the following conditions and then **CIRCLE** problematic areas on body to right:

- Neck Pain/Stiffness
- Back Pain/Stiffness
- Arm/Hand Pain
- Leg/Knee Pain
- Headaches
- Night Pain
- Depression
- Cold Extremities
- Nervousness
- Sleeping Difficulties
- Jaw Problems
- Loss of Smell
- Fainting
- Dizziness
- Stomach Problems
- Asthma
- Swollen Joints
- Changes
- Mood Changes
- Foot Trouble
- Pins/Needles in Arms
- Pins/Needles in Legs
- Light Bothers Eyes
- Recent Weigh Change
- Loss of Memory
- Nausea
- Loss of Taste
- Fatigue
- Chest Pain
- Tension
- Fever
- Cold Sweats
- Constipation/Diarrhea
- Allergies
- Shortness of Breath
- Blurred/Double Vision
- Bowel/Bladder
- Trouble Concentrating
- Loss of Balance



Please **CHECK** if you have ever had any of the following:

- ADD/ADHD
- Aids/HIV
- Alcoholism
- Allergy Shots
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma/Wheezing
- Bad Breath/Bad Taste
- Bleeding Disorders
- Blood Pressure: High or Low (circle)
- Breast Lump
- Broken Bones
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Colon Trouble
- Contacts/Glasses
- Diabetes**
- Dry Skin
- Ear Infections
- Epilepsy
- Fractures
- Gall Bladder
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heartburn
- Heart Attack
- Heart Problems
- Hemorrhoids
- Hepatitis
- Hernia
- Herniated Disc
- Herpes
- High Cholesterol
- Hormone/Gland Problems
- Insomnia
- Kidney Problems
- Liver Disease
- Measles
- Menopausal Prob.
- Migraines
- Miscarriage
- Mononucleosis
- Mouth Sores or Bleeding Gums
- Multiple Sclerosis
- Mumps
- Nosebleeds
- Osteoporosis
- Pacemaker**
- Parkinson's Disease
- Pinched Nerve
- Pneumonia
- Polio
- Prostate Problems
- Prosthesis
- Psychiatric Care
- Rheumatoid Arthritis
- Rheumatic Fever
- Scarlet Fever
- Sexual Difficulty
- Stroke
- Suicide Attempt
- Thyroid Problems
- TMJ Pain
- Tonsillitis
- Tremors
- Tuberculosis
- Tumors/Growths
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease
- Whooping Cough
- Other: \_\_\_\_\_

Are you currently under drug and/or medical care?  Yes  No If YES, explain \_\_\_\_\_

Please list **ALL** surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

Please list any supplements you are currently taking (vitamins/herbs/minerals): \_\_\_\_\_

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

- Heart Disease \_\_\_\_\_
- Cancer \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Stroke \_\_\_\_\_
- Thyroid Problems \_\_\_\_\_
- Fibromyalgia \_\_\_\_\_
- Other \_\_\_\_\_

Do you exercise:  Frequently  Moderately  Occasionally  None

Do your daily activities mostly involve: Hours Spent **SITTING/Day**: \_\_\_\_\_ Hours Spent **STANDING/Day**: \_\_\_\_\_

**LIFTING REQUIRED:** \_\_\_Light \_\_\_Moderate \_\_\_Heavy  Light Labor  Heavy Labor

Do you sleep on your:  Back  Side  Stomach Do you use a cervical pillow?  Yes  No

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete and accurate information during my exam.

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

**WOMEN ONLY: X-RAY QUESTIONNAIRE**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: \_\_\_\_\_

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because:

\_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT TO CARE

I hereby give my permission and authority for care. I authorize the doctors to order appropriate tests for diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care maybe contraindicated. It is the responsibility of the patient to make it known or to learn though health care procedures from whatever he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the physician. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I agree to settle any claim or dispute I may have against or with any of these persons or entities whether related to the prescribed care or otherwise will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

## POLICIES

1. All first visit charges are payable when services are rendered, since it is impossible to determine what Insurance covers without a diagnosis of severity.
2. The fee paid for X-rays is for the analysis of those X-rays only. The x-rays are the property of this office. Copies can be made at a minimal fee.
3. **Method of payment for today's charges:** \_\_\_\_\_Cash    \_\_\_\_\_Check    \_\_\_\_\_Visa / MasterCard

### MINOR

Consent to evaluate and treat a minor and/ or child: I, \_\_\_\_\_ (Print name) being the parent or legal guardian of \_\_\_\_\_ (Print name) give permission for my child to receive any care.

I have read and understand the foregoing.

*Per HIPAA Compliance, we may not discuss your health information with any family members or care-givers, unless you give our office permission. Please list the persons that you give Platinum Healthcare permission to discuss your health information with. (Examples: Care-giver, spouse, child, or close friend)*

Name	Relationship	Phone #
1. _____	_____	_____
2. _____	_____	_____

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

## How we protect your Health Information:

### Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Platinum Healthcare Physical Medicine** (hereinafter referred to as the "Practice") to use and disclose **protected health information (PHI)** about me to carry out **treatment payment and healthcare operations (TPO)**.

The Practice's Notice of Privacy Practices provides a more complete description of such uses and Disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Tamara Logan, at the following address:

5560 Bee Ridge Road, Suite 7, Sarasota, FL 34233.

With this consent, the Practice may call my home or other alternative location and leave a message on voice mail or in person in reference to my items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
*Signature of Legal Guardian (e.g. if a minor)*

\_\_\_\_\_  
*Relationship to minor*

HIPPA GENERAL LLC  
954-202-01066

**NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

For any **YES** answer, please explain under comment and notify the Doctor:

- |   |    |     |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?<br>Comment: _____  | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?<br>Comment: _____   | NO | YES |
| 3. Do your hands or arms fall asleep regularly?<br>Comment: _____   | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?<br>Comment: _____   | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?<br>Comment: _____  | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?<br>Comment: _____   | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?<br>Comment: _____  | NO | YES |
| 8. Do our legs or feet fall asleep regularly?<br>Comment: _____   | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?<br>Comment: _____  | NO | YES |
| 10. Do you suffer from cold hands or feet?<br>Comment: _____  | NO | YES |
| 11. Have you tried any medications such as anti-inflammatory?<br>If yes, what kind of medication? _____                                   | NO | YES |
| 12. Have you tried any Physical Therapy or Chiropractic treatments before?<br>If yes: When? For how long? What kind? _____<br>_____       | NO | YES |
| 13. Have you had an MRI? If yes: When? Who ordered it? What was it ordered for? _____   | NO | YES |
| 14. Have you used any splint or braces or other prescribed treatment by an MD?<br>If yes: When? What kind? Who ordered it? _____<br>_____ | NO | YES |
| 15. If you have tried any treatment or medications, did this make your problem better?<br>Comment: _____                                  | NO | YES |

**NOTE: Your health information will be kept strictly confidential.** Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

\_\_\_\_\_  
Patient Signature