Jerrold A. Friedman, MD

Physical Medicine and Rehabilitation

Patient Information

Name:_____ Date:_____

DOB:_____ Sex: ___M ___F Family Doctor:_____

Doctor Who Referred You:_____

Address:_____ City:_____ State:____ Zip:_____

Home Ph:_____ Cell Ph:_____ Work Ph:_____

Email:_____ Preferred Contact Method:_____

Martial Status:_____ Occupation:_____

IN CASE OF EMERGENCY CONTACT:

Name:_____ Relationship:_____

Home Ph:_____ Cell Ph:_____ Work Ph:_____

Is this injury a result of an auto accident or an on-the-job accident?_____

Insurance Information

Name of Insurance Company:_____

Name of Person Responsible for the Plan:_____

Are you the policy holder, spouse or dependent on plan?_____

Does your plan require a referral (HMO or Managed Care)?_____

Accident Insurance Information

Date of Accident:_____ Type of Accident:_____ Claim Number:_____

Name of Insurance Company:_____

Name of Adjuster:_____ Telephone Number:_____

State Accident Took Place In:_____ Attorney Name and Number:_____

PLEASE READ CAREFULLY AND SIGN:

I authorize and agree to treatment by Dr. Jerrold A. Friedman. I authorize my insurance company to pay Dr. Jerrold A. Friedman for my care. I understand that I will be responsible for any balance, copayment, or deductible left by my insurance. I understand that I am responsible for any referral that may be required to see Dr. Jerrold A. Friedman.

_____ _____

Patient signature Date

Patient Medical History

Please Indicate (by circling the condition) If You Have Ever Had the Following:

AIDS/HIV	Alcoholism	Allergy Shots	Anemia	Anorexia	Anxiety	Appendicitis
Arthritis	Asthma	Bleeding Disorder	Bronchitis	Bulimia	Cancer	Cataracts
Chemical Abuse	Chicken Pox	Depression	Diabetes	Emphysema	Epilepsy	Fractures
Glaucoma	Goiter	Gonorrhea	Gout	Heart Disease	Hepatitis	Hernia
Herniated Disk	High Blood Pressure		High Cholesterol	Kidney Disease	Liver Disease	Measles
Migraine	Miscarriage	Mononucleosis	Multiple Sclerosis	Mumps	Osteoporosis	Pacemaker
Parkinson's	Pinched Nerve	Pnemonia	Polio	Prosthesis	Psychiatric Care	
Rheumatoid Arthritis		Rheumatic Fever	Scarlet Fever	Sexually Transmitted Disease		Stroke
Substance Abuse	Suicide Attempt	Thyroid Disease	Tonsillitis	Tuberculosis	Tumors/Growths	Typhoid Fever
Ulcers	Vaginal Infections	Whooping Cough		Other:_____		

Please Indicate Any SIGNIFICANT Family History:

Please Indicate the Dates of Last:

	Date
Physical	_____
Exam of Injured/Painful Area	_____
Xray of Injured/Painful Area	_____
MRI/CT of Injured/Painful Area	_____

Injuries or Surgeries You Have Had:

	Description	Date
Falls/Broken Bones	_____	
Head Injuries	_____	
Dislocation	_____	
Surgeries	_____	
	_____	

Please List Any Current Medications/Herbs/Supplements:

Please List Any Allergies:

Social Habits:

___ Smoking Packs/Day_____ ___ Alcohol Drinks/Weeks_____
___ Caffeine Cups/Day_____ ___ Other Substances Description_____

Name: Date:

Pain/Injury Information

What is the main problem you wish to discuss?

Where is your pain?

When were you injured?

How were you injured? *select from below*

motor vehicle accident work-related accident recreational accident no particular event

other *(please explain)*:

Circle the words that describe your pain:

aching	throbbing	stabbing	gnawing	sharp	tender
nagging	burning	exhausting	tiring	penetrating	numb
miserable	unbearable				

What time of day is your pain the worst?

morning afternoon evening bedtime/overnight

Rate your pain, describing it at its WORST in the past month:

none 1 2 3 4 5 6 7 8 9 10 pain as bad as imaginable

Rate your pain, describing it at its LEAST in the past month:

none 1 2 3 4 5 6 7 8 9 10 pain as bad as imaginable

Rate your pain, describing it at its AVERAGE in the past month:

none 1 2 3 4 5 6 7 8 9 10 pain as bad as imaginable

Rate your pain, describing it RIGHT NOW:

none 1 2 3 4 5 6 7 8 9 10 pain as bad as imaginable

Name: Date:

Pain/Injury Information

What makes your pain better?

What makes your pain worse?

Please indicate if you have had any of the following injection treatments and whether they helped you?

		Beneficial	Not Beneficial
a)	Joint	_____	_____
b)	Epidural	_____	_____
c)	Facet	_____	_____
d)	Trigger Point	_____	_____
e)	Sympathetic Block	_____	_____

Please indicate if you have experienced any of the following:

		Yes	No
a)	Lost control of bowels	_____	_____
b)	Lost control of urination	_____	_____
c)	Weakness in arms or hands	_____	_____
d)	Weakness in legs	_____	_____
e)	Men Only: Difficulty getting or maintaining an erection	_____	_____

Has your sleep been abnormal or have you experienced insomnia?

In the past month:

Before the onset of pain:

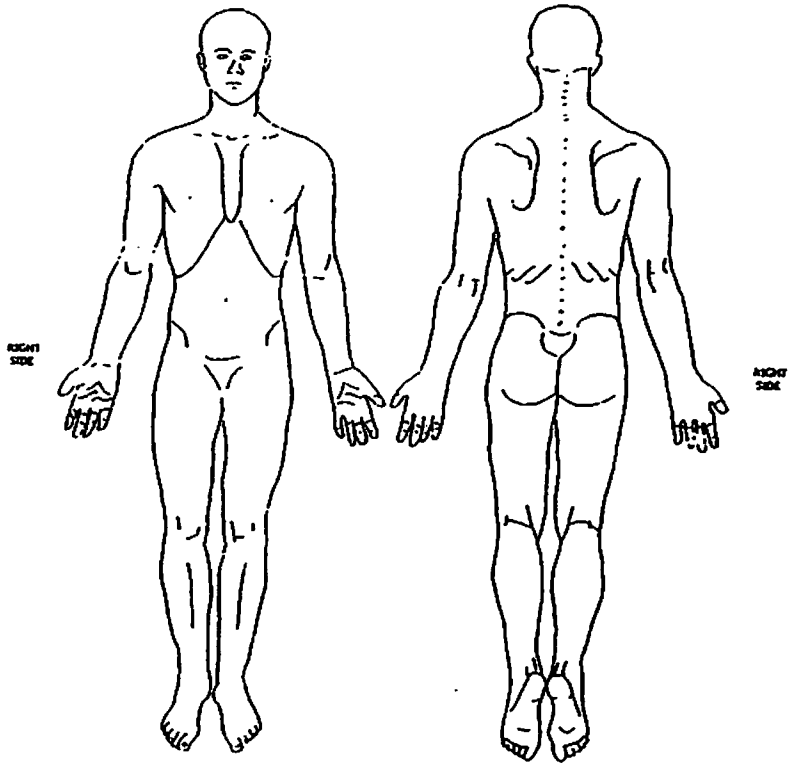
How much did you weigh when you were injured?

How much do you weigh now?

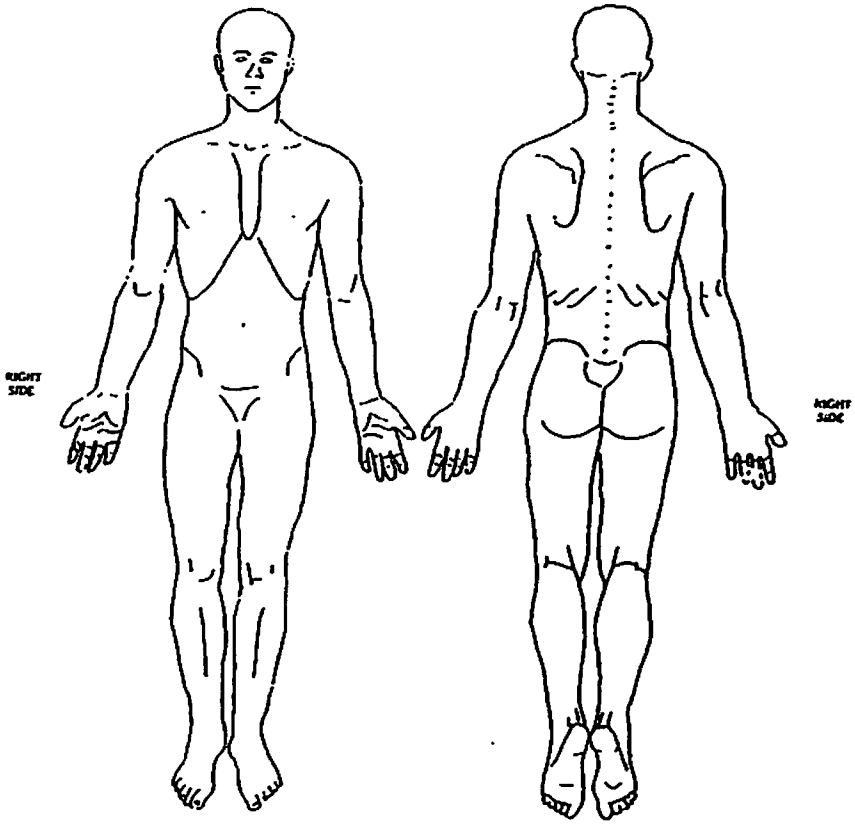
List any therapy programs and the approximate dates that you attended the program

Program	Dates	Beneficial	Not Beneficial

Please indicate where your pain is:



Please indicate where you have any "pins and needles" or numbness:



NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt of Notice of Health Privacy Practices and Authorization to Release Health Information.

By signing below, I acknowledge receipt of the notice of privacy practices of Jerrold Friedman, M.D. In addition, by signing below, I authorize Dr. Friedman to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

X_____ _____

Signature of Patient Date

TO BE COMPLETED ONLY IF NO SIGNATURE IS OBTAINED:

If it is not possible to obtain the individual's acknowledgment, describe the reasons why the acknowledgment was not obtained.

a.) Individual refused to sign.

b.) Communications barrier prohibited obtaining the acknowledgment.

c.) Emergency situation prevented us from obtaining the acknowledgment.

d.) Other_____.

X_____ _____

Printed Patient Name Date

You can pick this up on arrival.