ADVANCED PHYSICAL MEDICINE
RESTORE.RENEW.REGENERATE

8821 University East Drive Suite #120
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704.428.9006
www.apmr3.com

Please fill out the application entirely and legibly.

PERSONAL INFORMATION

Name_____Nickname_____

Address_____

City _____State _____ Zip _____

Phone _____Email_____

We will need to contact you by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth _____Social Security_____

Spouse's Name _____Phone Number _____

Your Occupation _____Retired? ☐Yes ☐ No

Primary Care Physician: _____

Address: _____

Telephone: _____

WORKERS COMPENSATION / PERSONAL INJURY:

Were you recently involved in a motor vehicle accident or worker's compensation case? YES NO

If yes, please inform the front desk.

PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

Insured's Name: _____ Insured's SS#: _____

Patient's Relationship To Insured: ___ Self ___Spouse ____Child ___Other: _____

Name of Insurance Company: _____

Address: _____

Insurance Phone #: _____ Policy Number: _____

SECONDARY INSURANCE

Insured's Name: _____ Insured's SS#: _____

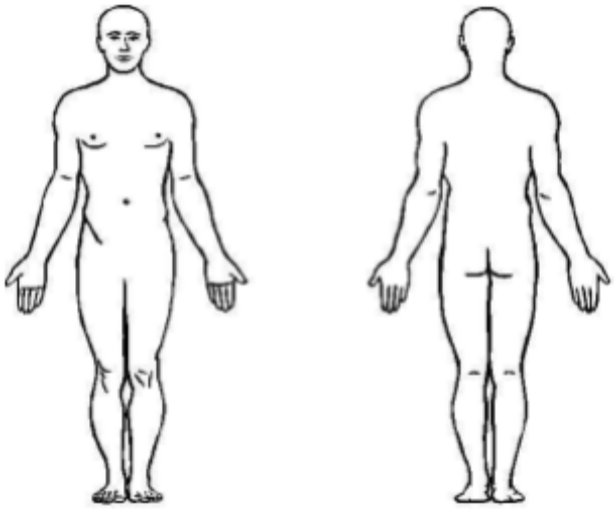
Name of Insurance Company: _____

Address: _____

Insurance Phone #: _____ Policy Number: _____

REVIEW OF SYMPTOMS → Please check ALL that apply

- ☐ Foot Pain
- ☐ Hand Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Vascular Problems
- ☐ High Blood Pressure
- ☐ Leg Pain
- ☐ Plantar Fasciitis
- ☐ Herniated Disc
- ☐ Morton's Neuroma
- ☐ Bulging Disc
- ☐ Cancer
- ☐ Spinal Stenosis
- ☐ Chemotherapy
- ☐ Degenerative Disc
- ☐ Arthritis in Hand
- ☐ Arthritis in Feet
- ☐ Implanted Cord/ Bladder Stimulator
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Poor Circulation
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Poor Wound Healing
- ☐ Excessive Thirst or Urination



❇ Please mark the area & type of pain on the drawings using the codes listed below.

N - Numbness T - Tingling S - Soreness P - Pain
A - Ache ST - Stiffness

Please explain if needed:

_____
_____
_____
_____
_____
_____

PRESENT HEALTH CONDITION

❇ In order of importance, list the health problems you are most interested in getting corrected.

1._____

2._____

_____

_____

❇ List approximately how long you have noticed these problems:

1._____

2._____

_____

_____

❇ Is there a certain time of day any of these problems are better or worse?

_____

_____

_____

❇ Circle the things you have used for these problems:

Gabapentin Neurontin Lyrica Cymbata
Physical Therapy Pain Medications Aleve
Tylenol Ibuprofen Motrin Chiropractic
Massage Therapy Injections Creams

❇ Is your balance/walking affected? *If yes, please describe:*

_____

_____

_____

❇ What do you think is causing your problem?

_____

_____

_____

❇ Name of all the doctors you have seen for these problems and treatment you received:

_____

_____

_____

❇ Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

❇ List anything that makes your condition worse_____

_____

_____

❇ List anything that makes your condition better_____

_____

_____

❇ How would you describe the symptoms? *Please check ALL that apply*

☐ Aching Pain	☐ Tingling	☐ Dead Feeling
☐ Stabbing Pain	☐ Pins & Needles Pain	☐ Cold Hands/ Feet
☐ Sharp Pain	☐ Heavy Feeling	☐ Cramping Swelling
☐ Tiredness	☐ Hot Sensation	☐ Burning
☐ Numbness	☐ Throbbing Pain	☐ Electric Shocks

❇ Is this condition interfering with any of the following?

☐ Sleep	☐ Work	☐ Standing
☐ Recreational	☐ Walking	
☐ Activities	☐ Daily Activities	

SOCIAL HISTORY

Do you smoke? ☐Yes ☐No If yes, how many cigarettes daily? _____

Do you drink? ☐Yes ☐No If yes, how often? _____

Do you exercise regularly? ☐Yes ☐No If yes, how often? _____

CURRENT PAIN LEVELS

❇ How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

❇ If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

PREVIOUS HEALTH CONDITION

PAIN POSSIBLE: This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals as per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name: _____

Signature: _____ Date: _____

❇ Please give name, address and office number of your primary care physician.

Name _____ Phone _____

Address _____

❇ When were you last seen there? _____

❇ May we send them updates on your treatment/condition? ☐Yes ☐No

❇ List ALL allergies/sensitivities to medication, food, and other items here: Reaction:

_____ _____

_____ _____

_____ _____

❇ List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking any prescription blood thinners? YES NO If yes, which one:

___Coumadin	___Orgaran	___Prasugrel
___Heparin	___Innohep	___ReoPro
___Lovenox	___Fragmin	___Ticlid
___Warfain	___Argatroban	___Trental
___Pradaxa	___Plavix	___Persantine
___Debigatran	___Effient	___Other: _____

Reason why you're taking blood thinners: _____

❇ List all nutritional supplements (vitamins, herbs, homeopathic, etc.) as above :

Name	Dose (mg or IU)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

❇ Please mark the following that applies:

- ☐ Post Organ Transplant or on Transplant List
- ☐ Immunocompromised
- ☐ HIV Positive
- ☐ Active Flu-Like Symptoms
- ☐ Pregnant, or Trying To Become Pregnant
- ☐ Active Cancer /Active Cancer in Last 5 Years
- ☐ Significant Food/Drug Allergies
- ☐ Known Sensitivity To Glycerol