PLATINUM HEALTHCARE
PHYSICAL MEDICINE

Health Questionnaire

First_____ M I_____ 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 :

- ☐ Back Pain (Mid/Low)
- ☐ Neuropathy
- ☐ Neck Pain
- ☐ Headaches /Migraines
- ☐ Fibromyalgia
- ☐ Tension across Top of Shoulders
- ☐ Shoulder Pain
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Pain in the Legs/Feet
- ☐ Hip Pain
- ☐ Knee Pain/Arthritis
- ☐ Tired /Fatigued /Difficulty Sleeping
- ☐ Allergies
- ☐ Digestive Problems
- ☐ 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
- ◆ Physical Therapy…Helped: Little Some Much
- ◆ Chiropractic… Helped: Little Some Much
- ◆ Exercise… Helped: Little Some Much
- ◆ Nutrition… 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:**____ /____/__ _

5560 Bee Ridge Road, Suite 7 Sarasota, FL 34233 (941) 927- 1123 F: (941) 927-1124

PLATINUM HEALTHCARE
PHYSICAL MEDICINE

Application for Patient Care

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 ☐ 1-3 yrs ☐ 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)

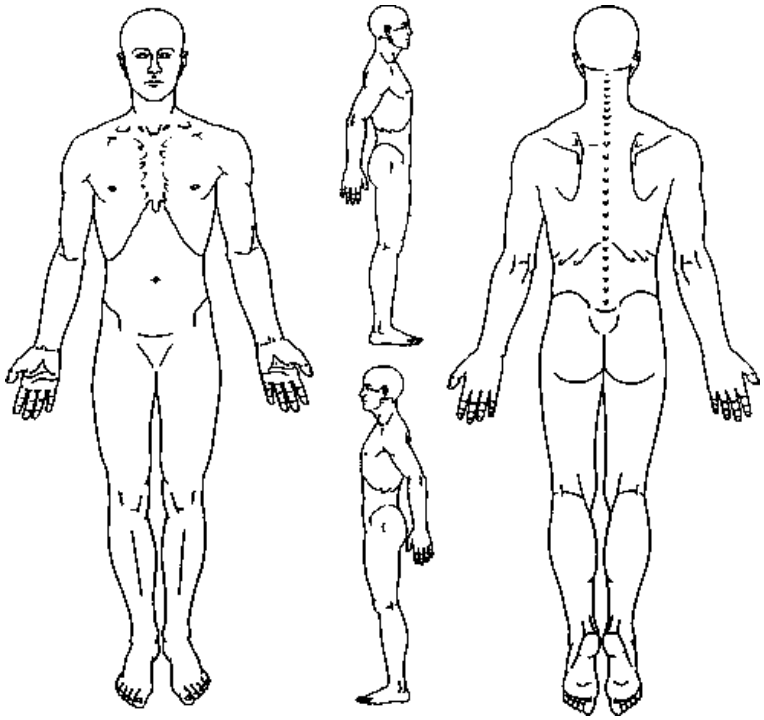
I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Platinum Health care Physical Medicine, LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible 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
- ❑ 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 Changes
- ❑ 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
- ❑ Heart burn
- ❑ 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 _____ ❑ Diabetes_____ ❑ Thyroid Problems _____
❑ Cancer _____ ❑ Arthritis_____ ❑ Fibromyalgia _____
❑ High Blood Pressure_____ ❑ Stroke_____ ❑ 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 am 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 here by giv e my permission and authority for care. I authorize the doct ors t o order appropriat e t ests for diagnosis and analy sis. The clini cal proce dures performe d are usually beneficial and seldom cause any problem. In rare cases underlying physical defe cts, deformities or pathologies may render the patient susce ptible for injury. The doct or, of course, will not provide spec ifi c he althcare if he /she is aware that such care maybe contraindicat e d. It is the responsibility of the patient to make it known or t o learn though health care procedures from what ever he/she is suffering from: lat ent pathological defe cts, illness or def ormities which would otherwise not come t o the att ention of the physician. I do not expect the doct or t o be able to anticipat e and explain all risks and complications, and I wish t o rely upon the doct or t o exercise judgment during the course of the proce du re which the doctor feels at the time, based upon the facts then known t o him or her, is in my best int erest.

I agree t o settle any claim or dispute I may hav e against or with any of these persons or entities whether relat e d t o the prescribe d care or oth erwise will be resolved by binding arbitration under the current malpractice t erms which can be obt aine d by writt en re quest.

POLICIES

1. All first visit charges are payabl e when services ar e ren der ed, since it is im possible 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. Th e x -rays ar e the propert y of this office. Copies can be m ade at a minim al 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 l egal guardian of _____ (Print name) give p ermission 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. Pl ease 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 outTPO.

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*

HIPPAA GENERAL LLC
954-202-010