FAMILY HEALTH
PHYSICAL MEDICINE LLC
2565 S. UNION AVE, ALLIANCE, OH. 44601
PHONE 330.821.4455 . FAX 330.821.4504

Pt #_____

Family Health Physical Medicine, LLC
2565 S. Union Ave, Alliance OH 44601

Patient Name_____ Date: _____ Email: _____
SS #/SIN_____ DOB_____ Gender at Birth ☐Male ☐Female Home phone_____Cell :_____:_____
Check appropriate Box**:** ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Patient's Address _____City _____ State_____ Zip_____
Employer Name: _____
Spouse or Patient's Guardian name_____ Spouse's Employer_____
Whom may we thank for referring you? _____
Person to contact in case of an emergency_____ Phone_____
In case of a medical emergency, if the patient is a minor, is ok to treat in my absence.

_____ _____
Parent or Guardian Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **FAMILY HEALTH PHYSICAL MEDICINE, LLC,** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This Assignment shall irrevocably assign and transfer benefits to Healthcare Provider as well as any cause of action arising from bad faith handling of this claim by any third party insurer. *******This Agreement shall authorize any and all Doctors or Health Care Organizations to release any medical information regarding my treatment to Healthcare Provider.******* This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ (SEAL)
(patient signature)

X_____(SEAL)
(signature of Guardian if applicable)

X_____
(please print patient name)

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Health History

Patient Name: _____DOB: _____Date:_____

What pain/problem brought you in to see us today?:

_____

History of Present illness:

How severe is the pain/problem?: _____ (On a scale of 1-10 with 10 being the most severe?)
How long have you had this pain/problem?: _____
What makes the pain/problem worse? _____ better? _____
What is the pain/ problem stopping you from enjoying ? _____
Is the pain/problem a result of an injury?: _____ If yes, was it a home, work or an auto injury?_____ When?_____

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles……	NO YES	Anemia……NO	YES	Back Trouble……NO	YES	Hepatitis……NO	YES
Mumps……	NO YES	Bladder Infection…….NO	YES	High Blood Pressure……NO	YES	Ulcer……NO	YES
Chicken Pox……	NO YES	Epilepsy……NO	YES	Low Blood Pressure……NO	YES	Kidney Disease……NO	YES
Whooping Cough…	NO YES	Migraine Headaches. NO	YES	Hemorrhoids……..…..NO	YES	Thyroid Disease……NO	YES
Scarlet Fever……	NO YES	Tuberculosis……..NO	YES	Date of Last Chest X-Ray_____		Bleeding Tendency……NO	YES
Diphtheria……	NO YES	Diabetes……..NO	YES	Asthma……..NO	YES	Any Other Disease……..NO	YES
Small pox……	NO YES	**Cancer……..NO**	**YES**	Hives of Eczema……NO	YES	(Please List): _____	
Pneumonia……	NO YES	Polio……NO	YES	AIDS & HIV……NO	YES		
Rheumatic Fever…	NO YES	Glaucoma……NO	YES	Infectious Mono……NO	YES	**Do you feel depressed or anxious?**	
Arthritis……	NO YES	Hernia……NO	YES	Bronchitis……NO	YES	**Yes / No**	
Venereal Disease…	NO YES	Blood or Plasma Transfusion……NO	YES	Mitral Valve Prolapse ….NO	YES	**If yes, are your currently receiving care**	
				Stroke……NO	YES	**for depression/anxiety?_____**	

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____

Please list any allergies: _____

Please list current immunizations: _____

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

Medication: (include nonprescription) _____

_____

_____

Are you taking any medications (prescription or over the counter) for **acid indigestion**? ☐ YES ☐ NO
if YES what type: _____

Patient Social History:

Marital Status Single: _____ Married: _____
Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency: _____

Anything additional you would like the physicians to know:

_____

_____

CLINICIAN SIGNATURE: _____ DATE REVIEWED:_____

Health History continued:

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Name: _____ DOB _____ Date:_____

Indicate which of the below you currently experiencing
1=Never; **2**=Rarely; **3**=Occasionally; **4**=Frequently; **5**=Constantly

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient's Name (print) _____Signature_____Date_____

Parent or Guardian (print) _____Signature_____Date_____

Physician's Signature (upon review) _____ Date_____

- ☐ AMY R. HANNA, FNP-C
- ☐ THOMAS A. KRUPKO, MD, FACS
- ☐ NICK G. KOINOGLOU, DC, Dipl. Ac (IAMA)
- ☐ CADE LLOYD, DPT
- ☐ DONALD L. DOWNING, DPT
- ☐ ALEXIS HERRERA, DC

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NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME:_____ DATE:_____

For any YES answer, please notify the Doctor.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment:_____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment:_____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment:_____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment:_____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment:_____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment:_____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
   Comment:_____
9. Do you have reduced feeling (sensation) or swellings in your legs, feet? NO YES
   Comment:_____
10. Do you suffer from cold hands or feet? NO YES

    Comment:_____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment:_____
12. Do you have difficulty maintaining your balance? NO YES

    Comment:_____
13. Do you suffer from vertigo or blurred vision? NO YES

    Comment:_____
14. Do you suffer from a reduced hearing capacity? NO YES

    Comment:_____
15. Do you suffer from ringing in your ears? NO YES

    Comment:_____
16. Do you have bladder or bowel control problems on a regular basis? NO YES

    Comment:_____