

Pt # \_\_\_\_\_

**Family Health Physical Medicine, LLC**

2565 S. Union Ave, Alliance OH 44601



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

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 of this document is to be considered as valid and as enforceable as the original.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

X \_\_\_\_\_ (SEAL)

(signature of Guardian if applicable)

X \_\_\_\_\_ (SEAL)

(patient signature)

X \_\_\_\_\_

(please print patient name)

# 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	<b>Cancer.....</b>	<b>NO</b>	<b>YES</b>	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	<b>Do you feel depressed or anxious?</b>		
Arthritis.....	NO	YES	Hernia.....	NO	YES	Bronchitis.....	NO	YES	<b>Yes / No</b>		
Venereal Disease...	NO	YES	Blood or Plasma			Mitral Valve Prolapse	....NO	YES	<b>If yes, are your currently receiving care</b>		
			Transfusion.....	NO	YES	Stroke.....	NO	YES	<b>for depression/anxiety?</b>	_____	

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:



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. KOINOGLU, DC, Dipl. Ac (IAMA)
- ☐ DONALD L. DOWNING, DPT



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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: \_\_\_\_\_