AZ MEDICAL
AND SPORTS REHAB

Intake Form

Last Name ____________________________________ First Name __________________________ MI ____
Birthdate __________ Age _____ Email ____
Would you like to receive emails about specials and upcoming events? ☐Yes ☐ No
Address ____ City _______________ State _____ Zip _______
Phone (H)_______________________(W)_______________________(C)_______________________
Occupation _____________________________ Employer ____________________________________
Spouse's Name __________________________ Employer ____________________________________
Emergency Contact Name __________________________________ Phone _____________________
If under the age of 18, parent or guardian's name ____
In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.
____ ____________________
Parent or Guardian Date
How did you hear about us? Walk In ☐Social Media ☐Event ☐Yelp ☐Google
☐Referred by __________________________________ ☐Other ______________________________

Do you have any Medical insurance? ☐Yes ☐ No If yes, complete the following:
Name of the insured ____ Relationship to patient___________________
Birthdate _______________ SS#/SIN __________________ Phone ______________________
Name of Employer__________________________________ Phone_____________________
Address of Employer________________________________ State _____ Zip_____________
Insurance Company________________________Group #_______________ Union or local #__________________
Ins. Co. Address ________________________________ City ________________ State _____ Zip _____________

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 **Arizona Medical and Sports Rehab** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Health Care 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 Health Care 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 Health Care 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 Health Care 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 Health Care Provider, myself, and/or my family members as a result of services rendered by Health Care 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 Health Care Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Health Care 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, 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 Health Care Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Patient Name (print) ____ Date ___________
Patient Signature ____
Guardian Signature (if applicable) ____

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MEDICAL HISTORY

Chief Complaint: ____

____

History of Present illness:

Location____________________ **Quality** ____________________
(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc..)

Severity ____________________ **Duration** ____________________
(Scale of 1-10 with 10 being the most severe?) (How long have you had this pain/ problem? When did it start?)

Timing ____________________ **Context** ____________________
(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms ____
(What other associated problems have you been having?)

Modifying Factors____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Have you ever had the following? Check “yes” or “no”. Leave blank if you are uncertain.

Measels ❏ Yes ❏ No	Anemia ❏ Yes ❏ No	Back Trouble ❏ Yes ❏ No	Hepatitis ❏ Yes ❏ No	Arthritis ❏ Yes ❏ No
Mumps ❏ Yes ❏ No	Bladder Infection ❏ Yes ❏ no	High Blood Pressure ❏ Yes ❏ No	Ulcer ❏ Yes ❏ No	Bronchitis ❏ Yes ❏ No
Chicken Pox ❏ Yes ❏ No	Epilepsy ❏ Yes ❏ No	Low Blood Pressure ❏ Yes ❏ No	Kidney Disease ❏ Yes ❏ No	Venereal Disease ❏ Yes ❏ No
Whooping Cough ❏ Yes ❏ No	Migraine Headaches ❏ Yes ❏ No	Hemorrhoids ❏ Yes ❏ No	Thyroid Disease ❏ Yes ❏ No	Blood/Plasma Transfusion ❏ Yes ❏ No
Scarlet Fever ❏ Yes ❏ No	Tuberculosis ❏ Yes ❏ No	Bleeding Tendency ❏ Yes ❏ No	Diphtheria ❏ Yes ❏ No	Mitral Valve Prolapse ❏ Yes ❏ No
Diabetes ❏ Yes ❏ No	Asthma ❏ Yes ❏ No	Smallpox ❏ Yes ❏ No	Cancer ❏ Yes ❏ No	Stroke ❏ Yes ❏ No
Hives of Eczema ❏ Yes ❏ No	Pneumonia ❏ Yes ❏ No	Polio ❏ Yes ❏ No	AIDS & HIV ❏ Yes ❏ No	Date of Last X-Ray: ____________
Rheumatic Fever ❏ Yes ❏ No	Glaucoma ❏ Yes ❏ No	Infection Mono ❏ Yes ❏ No	Hernia ❏ Yes ❏ No	Any Other Disease: ____________

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Previous Hospitalizations/Surgeries/Serious Illnesses

When? Hospital, City, State

______________________ ____

______________________ ____

______________________ ____

Medication: (include nonprescription)

____

____

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Are you taking any medications (prescription or over the counter) for acid indigestion? ☐ Yes ☐ No

If yes, please list ____

Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Drugs: ☐ Never ☐ Yes If yes, type/frequency ____

Excessive Exposure Do you have excessive exposure to any of the following at home? Please check all.

☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne Particles ☐ Noise

Family Medical History

	Age	Disease	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

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Eyes/Ears/Nose/Throat/Respiratory & Musculoskeletal

Asthma 1 2 3 4 5	**Muscle Aches** 1 2 3 4 5	**Stuffy Nose** 1 2 3 4 5	**Fibromyalgia** 1 2 3 4 5
Hay Fever 1 2 3 4 5	**Arthritis** 1 2 3 4 5	**Sore Throat** 1 2 3 4 5	**Joint Pain** 1 2 3 4 5
Chronic Cough 1 2 3 4 5	**Low Back Pain** 1 2 3 4 5	**Chest Congestion** 1 2 3 4 5	**Neck Pain** 1 2 3 4 5
Frequent Sneezing 1 2 3 4 5	**Wrist/Hand Pain** 1 2 3 4 5	**Itchy/Watery Eyes** 1 2 3 4 5	**Elbow Pain** 1 2 3 4 5
Drainage 1 2 3 4 5	**Shoulder Pain** 1 2 3 4 5	**Earache/Ear Infection** 1 2 3 4 5	**Hip Pain** 1 2 3 4 5
Itching 1 2 3 4 5	**Knee Pain** 1 2 3 4 5	**Hoarseness** 1 2 3 4 5	**Ankle/Foot Pain** 1 2 3 4 5
Shortness of Breath 1 2 3 4 5	**Pain b/t Shoulder blades** 1 2 3 4 5	**Wheezing** 1 2 3 4 5	

Neurological & General

Headaches 1 2 3 4 5	**Fatigue** 1 2 3 4 5	**Migraines** 1 2 3 4 5	**Malaise** 1 2 3 4 5
Dizziness 1 2 3 4 5	**Weakness/Tiredness** 1 2 3 4 5	**Numbness** 1 2 3 4 5	**Lightheadedness** 1 2 3 4 5
Tingling 1 2 3 4 5	**Irritability** 1 2 3 4 5	**Pins/Needles in Hands/Feet** 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 Signature Date

______________________________ ____________________

Parent/Guardian Signature (if applicable) Date

______________________________ ____________________

Doctor's Signature Date