KEVIN H. WEINER MD

BOARD CERTIFIED

PHYSICAL MEDICINE AND REHABILITATION

NEW PATIENT INFORMATION

Patients Name: _____Todays Date: _____

Home Address: _____

City, State, Zip Code: _____

Home Telephone: _____ Cell Phone: _____

Date of Birth: _____ SS#: _____

Emergency Contact: _____ Phone: _____

Email Address: _____

Primary Language: _____ Race: _____ Ethnicity: _____

INJUY INFORMATION

Date of Injury: _____ Time of Injury: _____

Job Title: _____

Injury Address: _____

Enter your usual job activities: _____

_____

How did the injury occur? _____

_____

Have you lost any time from work? YES NO How much time?:

_____

Other doctors seen for this injury:

_____

Have you had x-rays taken as a result of this injury? YES NO

If YES, where were they taken?

_____

Any previous workers compensation injuries? YES NO
If YES, dates of other workers compensation cases:

_____

EMPLOYER INFORMATION WHEN ACCIDENT OCCURRED

Employer Name: _____

Employer address: _____

City, State, Zip: _____

Employer Phone #: _____

Employer contact person and phone number: _____

WORKERS COMPENSATION INSURANCE INFORMATION

Insurance Name: _____

Insurance Address: _____

City, State, Zip: _____

Carrier Claim Number: _____ WCB Case Number: _____

Claim Adjuster Name and Phone Number: _____

ATTORNEY INFORMAION

Law Firm Name: _____

Attorney Name: _____ Attorney Phone Number: _____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied. I understand that filing for Workers Compensation benefits does not relieve me from my responsibility for the payment of all charges.

_____

Signature of patient, parent, guardian or personal representative

Date

_____

Print name of patient, parent, guardian or personal representative

Date

Medical Health Questionnaire

Patients Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Right or Left-handed (please circle one)

Name of Primary Physician: _____ Office #: _____

Address: _____

Name of Referring Physician: _____ Office #: _____

Address: _____

Preferred Pharmacy: _____ Town: _____

PRIOR SIGNIFICANT MEDICAL ILLNESS (please circle)

Cancer	NO	YES		Hypertension		NO	YES
Diabetes	NO	YES		Stroke	NO	YES	
Hepatitis	NO	YES		Tuberculosis	NO	YES	
Heart Disease	NO	YES					

OPERATIONS (please circle)

Prior Surgery	NO	YES		Hypertension	NO	YES	
Cataracts	NO	YES		Hysterectomy	NO	YES	
Heart Surgery	NO	YES		Tonsils		NO	YES
Other Surgeries	NO	YES	Please specify: _____				

MEDICATIONS CURRENTLY TAKING

Prescription Drugs

Name: _____ Dose: _____

Name: _____ Dose: _____

Over the counter Medications

Name: _____ Dose: _____

Name: _____ Dose: _____

ALLERGIES AND SENSITIVITIES (please circle)

Aspirin NO YES Penicillin NO YES

Codeine NO YES Sulfur NO YES

Iodine NO YES

Other Antibiotics (list) _____

Any Food(s) _____

Other drugs (list) _____

SOCIAL HISTORY (please circle)

Single Married Divorced Widowed

Alcoholic Beverages: Never Rarely Moderately Frequently

Tobacco: Cigarettes NO YES Packs/Day: _____

Cigar NO YES

Pipe NO YES

Occupation: _____ Retired NO YES

FAMILY HISTORY (please circle)

Father Age: _____ Health Status Living Deceased

Mother Age: _____ Health Status Living Deceased

Sibling Age: _____ Health Status Living Deceased

Sibling Age: _____ Health Status Living Deceased

Sibling Age: _____ Health Status Living Deceased

FAMILY HISTORY (please circle)

Arthritis NO YES Gout NO YES

Bleeding Tendencies NO YES Heart Disease NO YES

Cancer NO YES High Blood Pressure NO YES

Convulsions NO YES Stroke NO YES

Diabetes NO YES Tuberculosis NO YES

MEDICAL HISTORY QUESTINNAIRE (Ros)

Do you have any problems in the following areas? (Check yes or no)

General	YES	NO		**GI/GU**	YES	NO
Fever	___	___		Vomiting	___	___
Fatigue		___	___	Bloody bowel movement		___
Weight loss or gain	___	___		Heartburn	___	___
Frequent colds	___	___		Loss of appetite	___	___
EYES				Difficulty W/ urine	___	___
Blurred vision		___	___	Blood in urine		
Double Vision		___	___	Frequent urination		___
Redness	___	___		Pain while urinating	___	___
Sandy or gritty feeling		___	___	**MUSCULOSKELETAL**		
Blind spots	___	___		Muscle pain	___	___
Floater		___	___	Joint pain/arthritis		___
Flashes		___	___	**INTEGUMENTARY**		
Lazy eye	___	___		Rash, bruise easily	___	___
Itching, burning	___	___		Breast Disease		___
Excess tearing		___	___	**NEUROGICAL**		
Glare/light sensitivity		___	___	Fainting		___
Eye pain	___	___		Frequent headaches		___
Chronic infection eye/lid	___	___		Seizures	___	___
ENT: EARS/NOSE/THROAT				PSYCHIATRICH		
Sinus infection		___	___	Depression		___
Cough	___	___		Anxiety	___	___
Trouble walking	___	___		Psychiatric problems		___
Hoarseness	___	___		**ENDOCRINE**		
Loss of hearing	___	___		Excessive thirst	___	___
Nose bleeds	___	___		Excessive sweating	___	___
HEART						
HEMATOLOGIC/LYMPHATIC						
Chest pain	___	___		Swollen glands	___	___
Irregular heart burn	___	___		**ALLERGIC/IMMUNOLOGIC**		
Pacemaker	___	___		Seasonal allergies	___	___

Heart murmur	___	___	Hay fever		___
Swollen feet/ankles	___	___	**OTHER**		
Leg cramps when walking	___	___	Pregnant	___	___
LUNGS			Menopausal	___	___
Wheezing/shortness of breath	___	___	Vaginal Bleeding		___
Coughing up blood/phlegm	___	___	Breast lumps	___	___

Kevin H. Weiner

1. I acknowledge that I have been given a copy of the practices “HIPPA Privacy notice” which describes the practices obligation to ensure the privacy of any health information. The HIPPA Privacy Notice also describes how the practice may use and discuss any health information for treatment, payment, and health care options. I know that I have the right to review the practices HIPPA Privacy Notice and to ask questions about it. I understand that the practice is required to maintain the privacy of my health information in accordance with the terms of its HIPPA Privacy Notice.
2. I further acknowledge that the practice can change its HIPPA Privacy Notice in the future and that I can receive a copy of the practices current Privacy Notice at any time by contacting the office at (718) 442-4422.
3. I understand that I have the right to request that the practice restricts its uses and disclosures of my health information for treatment, payment, or health care operations. If my restrictions are accepted by the practice, these restrictions will be binding on the practice. I also understand that practice is not required to agree to any of my restrictions.

   I do not request or restrict on the practice’s uses of disclosures of my health information for treatment, payment, or health care operations.

   _____ (Initial)
4. By Signing this form, I consent to the practices use and disclosure of my health information for treatment, payment, and health care operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not have an effect on any actions the practice has already taken in reliance on this consent.

X_____

Signature of patient or patient representative Date

If this form is signed by a patient representative please complete the following:

Print the name of the patient's representative: _____

Describe the representative's authority to act for the patient _____

NOTE: YOU MAY REFUSE TO SIGN THIS CONSENT, HOWEVER, IF YOU DO REFUSE,

THE PRACTICE MAY REFUSE TO PROVIDE YOU WITH NON-EMERGENCY CARE.

Total Body Orthopedics & Rehabilitation
963 Post Ave.
Staten Island NY 10302
Telephone: 718-442-4422
Fax: 718-556-3025

12 Hudson Valley Professional Plaza
Newburgh, NY 12550
Telephone: 845-561-1581
Fax: 845-784-4540

PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I understand that if I break this agreement, my doctor will stop prescribing pain control medications.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances including marijuana, cocaine, etc..

I will not share, sell, or trade my medications with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other Doctor. Breaking of this agreement will result in discharge from this practice.

I agree that refills of my prescriptions for pin medications will be made only at the time of my office visit or during regular office hours. No refill will be available during evenings or weekends.

Pharmacy Name: _____

Address and Phone Number: _____

_____

I agree to use the above pharmacy for filling prescriptions for ALL my medicines.

I authorize the doctor and my pharmacy to cooperate fully within any city, state, or federal law enforcement agency, including this states board of pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test, if requested by my doctor’s office to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unuse pain medicines to every office visit.

I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Date of this agreement: _____

Patient Name: _____

Patient Signature: _____

Physician Signature: _____

Witnessed by: _____

INITIAL VISIT

TO BE COMPLETED BY THE PROVIDER

Patient Name: _____Injury Date: _____ Todays Date:_____

When did symptoms first appear? _____When did patient first consult you for this condition?_____

Has patient ever had same or similar condition? [ ] YES [ ] NO

If "YES" state when and describe:

_____

_____

Is this condition solely a result of a result of this automobile accident? [ ] YES [ ] NO

If "NO" explain:_____

_____

Is this condition due to injury arising out of the patients employment? [ ] YES [ ] NO

Will injury result in significant disfigurement or permanent disability? [ ] YES [ ] NO

If "YES" describe: _____

_____

Will the patient require rehabilitation and/or occupational therapy as a result of the injuries sustained in the accident?

[ ] YES [ ] NO If "YES" describe your recommendation below in the "PLAN OF CARE" section

Is the patient still under your care for this treatment? [ ] YES [ ] NO

INJURY HISTORY

Based on the patient's history, where and how did the injury/illness happen:

_____

_____

How did you learn about the injury/illness (check one)

[ ] Patient [ ] Medical Records [ ] Other (specify):

_____

Did another health provider treat this patient?

[ ] YES [ ] NO If yes give details: _____

Have you previously treated this patient for a similar work-related injury/illness? [ ] YES [ ] NO if "YES" when: _____

EXAM INFORMATION

Patients subjective complaints: Check all that apply and identify specific affected body part(s)

[ ] Numbness/tingling: _____ [ ] Swelling: _____
[ ] Pain: _____ [ ] Weakness: _____
[ ] Stiffness: _____ [ ] Other (specify): _____

Type/nature of injury: Check all that apply and identify specific affected body part(s)

[ ] Abrasion: _____ [ ]Infectious Disease:_____
[ ] Amputation: _____ [ ] Inhalation Exposure: _____
[ ] Avulsion: _____ [ ] Laceration: _____
[ ] Burn: _____ [ ] Needle Stick: _____
[ ] Confusion: _____ [ ] Poisoning/Toxic effects: _____
[ ] Crush Injury: _____ [ ] Psychological: _____
[ ] Dermatitis: _____ [ ] Puncture Wound: _____
[ ] Dislocations: _____ [ ] Repetitive strain injury: _____

PATIENT NAME: _____ INJURY DATE: _____ TODAYS DATE: _____

[ ] Fracture: _____ [ ] Spinal Cord injury: _____
[ ] Hearing Loss: _____ [ ] Sprain/Strain: _____
[ ] Hernia: _____ [ ] Torn Ligament/Tendon/Muscle: _____
[ ] Other (specify): _____ [ ] Vision: _____

Physical examination: Check all relevant objective findings and identify specific affected body part(s):

[ ] None to present
[ ] Bruising: _____ [ ]Neuromuscular Findings: _____
[ ] Burns: _____ [ ] Abnormal/ Restrictions ROM: _____
[ ] Crepitation: _____ Active ROM : _____
[ ] Deformity: _____ Passive ROM: _____
[ ] Edema: _____ [ ] Gait: _____
[ ] Herniation/Lump/Swelling: _____ [ ] Palpable muscle spasm: _____
[ ] Joint Effusion: _____ [ ] Reflexes: _____
[ ] Laceration/Sutures: _____ [ ] Sensation: _____
[ ] Pain/Tenderness: _____ [ ] Strength (weakness): _____
[ ] Scar: _____ [ ] Wasting/Muscle Atrophy: _____
[ ] Other: _____

Describe any diagnostic test(s) rendered at this visit:

_____

Describe any treatment(s) rendered at this visit: _____

Describe prognosis for recovery: _____

Does this patients medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? [ ] YES [ ] NO If “YES” give details:

_____

DOCTORS OPINION

In your opinion, was the incident that the patient described the component medical cause of the injury/illness? [ ] YES [ ] NO

Are the patients complaints consistent with his/her history of the injury/illness? [ ] YES [ ] NO

Is the patients history of the injury/illness consistent with your objective findings? [ ] YES [ ] NO

What is the percentage (0-100%) of temporary impairment? [ ] YES [ ] NO

Describe findings and relevant diagnosis test results:

_____

_____

PLAN OF CARE

What is your proposed treatment? _____

_____

Medication(s)

Medications prescribed: _____

Medications over-the-counter advised: _____

Medication restrictions: [ ] NONE

[ ] May affect patients ability to return to work, make patient drowsy, or the issue. Please explain how:

_____

PATIENT NAME: INJURY DATE: TODAYS DATE:

_____

Does the patient need diagnostic tests or referrals? [ ] YES [ ] NO if "YES" please check all that apply

[ ] CT Scan

[ ] EMG/NCS

[ ] MRI specify:_____

[ ] Labs specify: _____

[ ] X-rays specify: _____

[ ] Other: _____

[ ]Chiropractor: _____

[ ] Internist/Family Physician: _____

[ ] Occupational Therapist: _____

[ ] Physical Therapist: _____

[ ] Specialist: _____

Assistive devices prescribed for this patient:[ ] Care[ ] Crutches [ ] Orthotics[ ] Walker

[ ] Wheel chair

[ ] Other: _____

When is the patients next appointment?

[ ] within a week [ ] 1-2 weeks [ ] 3-4 weeks [ ] 5-6 weeks[ ] 7-8 weeks [ ] ___ months

[ ] as needed

WORK STATUS

Has patient missed work because of the injury/illness? [ ] YES [ ] NO If "YES" date patient first missed?

Is patient currently working [ ] YES [ ] NO If "YES" did the patient return to

[ ] usual work activities [ ] limited work activities

Can patient return to work (check all that apply)

[ ] The patient cannot return to work because (explain): _____

[ ] The patient can return to work without limitations on: _____

[ ] The patient can return to work with the following limitations (check all that apply) on: _____

[ ] Bending/sitting [ ] Lifting [ ] Sitting

[ ] Climbing stairs/ladders [ ] Operating heavy equipment [ ] Standing

[ ] Environmental conditions [ ] Operating of motor vehicle [ ] Use of public transport

[ ] Kneeling [ ] Personal Protective equipment [ ] Use of upper extremities

[ ] Others: _____

Describe/quantify the limitations: _____

_____

How long will these limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] unknown

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BOARD AUTHORIZED HEALTH CARE PROVIDER (check one)

[ ] I provided the services listed above

[ ] I actively supervised the health-care provider named below who provided these services

Providers name: _____ Specialty: _____

X_____ Date: _____

Kevin H. Weiner MD PC