PATIENT INFORMATION

DATE: ____________________

TO BE FILLED OUT BY PATIENT:

Patient Name: ______________________________ Soc. Sec. #: ____________

Address ______________________________ Date of Birth: ____________ Sex: ☐ Male ☐ Female

City ____________ State ________ Zip ________ Marital Status: ____________

Phone #: ____________________ Cell: ____________________

E-MAIL: ____________________ Driver License#: ____________________

Emergency Contact: ______________________________

HOW DID YOU FIND US?: ______________________________

ATTORNEY NAME ______________________________ Phone #: ____________________

Case Manager ______________________________ Fax: ____________________

LOP Received: ☐ YES ☐ NO **DATE OF INJURY:** ____________________

PATIENT'S AUTO INSURANCE INFORMATION

Name of Insurance Company ______________________________ Claim #: ____________

Address: ____________________ City ____________ State ________ Zip ________

Name of INSURED: ____________________ Policy #: ____________________

Phone#: ____________________ Fax#: ____________________

Agent Name: ____________________ **Agent Number:** ____________________

PIP: ☐ YES ☐ NO AMT$ ____________ MEDPAY: ☐ YES ☐ NO $ ____________ UM: ☐ YES ☐ NO

3rd PARTY INSURANCE INFORMATION (OTHER VEHICLE)

Name of Insurance Company ______________________________

Address: ____________________ City ____________ State ________ Zip ________

Name of INSURED: ____________________ Soc. Sec.# ____________________

Phone#: ____________ Fax#: ____________ Policy#: ____________

PATIENT HEALTH INSURANCE INFORMATION

Name of Insurance Company ______________________________

Address: ____________________ City ____________ State ________ Zip ________

Name of INSURED: ____________________ Soc. Sec.# ____________________

Phone#: ____________ Fax#: ____________ Plan/Group#: ____________

TO BE FILLED OUT BY STAFF ONLY:

LOCATION: EAST NORTH SOUTHWEST MIDTOWN

IRREVOCABLE ASSIGNMENT OF PROCEEDS AND CONVEYANCE OF LIEN INTEREST
(Not a Statutory Lien)

Re: Medical Reports and Lien for ____

I do hereby authorize **Nisal Corp. (dba Qualcare Rehabilitation)** and **Avant Medical Group, PA. (dba Allied Medical Centers)** to furnish my attorney, and/or the insurance carrier, with complete report of my medical examination, treatment, prognosis, etc. (including notes, x-rays, and other medical data, as determined necessary by my treating doctor), relating t my health care treatment in regard to the accident/injury or other contributing incident giving rise to my need for such health services.

IRREVOCABLE ASSIGNMENT OF PROCEEDS AND CONVEYANCE OF LIEN INTEREST

I hereby execute and provide this **Irrevocable Assignment of Proceeds and Conveyance of Lien Interest** in favor of Avant Medical Group, P.A. and Nisal Corp. This **Irrevocable Assignment of Proceeds and Conveyance of Lien Interest** shall apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to be paid in the form of an insurance settlement(s), claim(s), or verdict(s) resulting from the above identified accident (collectively the "insurance proceeds").

The Insurance Carrier is instructed that pursuant to this **Irrevocable Assignment of Proceeds and Conveyance of Lien Interest** the total dollar amount of all sums which I owe on account to the above treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility as compensation for their professional services provided to me.

As consider for my execution of this **Irrevocable Assignment of Proceeds and Conveyance of Lien Interest** I represent that said doctor and/or treating facility has provided me professional medical services upon my request, that I am aware of the nature and expense of all such services so provided and that as consideration for my doctor's forbearance of his/her legal right to require payment by me at the time such medical services were rendered, said doctor and treating facility relied upon my express declaration and intention to execute and instruct that this Irrevocable Assignment of Proceeds and Conveyance of Lien Interest shall apply to all insurance proceeds to which I am or may be entitled and direct that the amount of any settlement proceeds required to satisfy my outstanding balance with said doctor and/or treating facility be remitted directly to the doctor and/or treating facility at such time as I receive an insurance settlement or other monetary settlement/award.

In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor/facility and remit payment of all such sums directly to such named doctor/facility upon demand by the said doctor/facility.

I fully understand and stipulate that I am ultimately and directly responsible to the doctor and/or treating facility for all medical bills incurred by me for those services rendered to me, or on my behalf or request, and that this is agreement is made solely for the benefit of the doctor and treating facility as additional protection and in consideration of the treating facility's agreement to forgo immediate collection of payment for such services rendered.

SIGNED: ____ **DATE:** __________________

PRINTED NAME OF PATIENT: ____

For or On Behalf of the Minor Child(ren): ____ ,do hereby assume full financial responsibility for the expense and payment of all services provided to me and to my minor child(ren), if any. I acknowledge that I am independently liable for the cost of all medical/chiropractic services so provided regardless of the existence of insurance coverage or payments.

SIGNED: ____ **DATE:** __________________

QUALCARE
REHABILITATION

1120 Dennis St., Houston, TX 77004
Phone: 713-652-3145 Fax: 713-652-3146

RELEASE OF PROTECTED HEALTH INFORMATION

TO ____

PHONE: ____________________________ FAX: ______________________________

2ND REQUEST__________________
3RD REQUEST__________________

Patient Name _____________________________________

Soc. Sec. #: ______________________________________

Date of Birth: _____________________________________

I, ______________________________, (for the purpose of treatment at this office), request and consent to the release of the following information:

❑ History ❑ X-rays ❑ Diagnosis ❑ Treatment ❑ Reports ❑ All Medical Records

Date of service: ____________________

Signed:____ Date: ____________________
Patient/Guardian

I certify that the Protected Health Information of the above referenced patient will be used solely for the purposes of treatment, payment and operations. This Clinic complies with all applicable federal privacy statutes.

Witness: ______________________________________ Date: ____________________
Privacy Officer

PATIENT: ______________________	SOCIAL SECURITY: ______________________

EMPLOYMENT HISTORY

Name of current employer: ______________________ ☐ Unemployed ☐ Unemployed due to injuries

Please describe type of work: ☐ Office / Clerical ☐ Light Labor ☐ Medium Labor ☐ Heavy Labor ☐ Other: __________

1. Did you lose any time from work due to your injuries? ☐ YES ☐ NO
2. Did employer know your time off was from the injuries? ☐ YES ☐ NO
3. How many days / hours did you lose from work to date? ______________________

MEDICAL HISTORY INFORMATION

1.	Severe Headaches	Y	N	16.	Stomach Problems	Y	N
2.	Loss of Conscious	Y	N	17.	Black or Blood Bowels	Y	N
3.	Epilepsy	Y	N	18.	Hernia	Y	N
4.	Dizziness / Fainting Spells	Y	N	19.	Kidney Problems	Y	N
5.	Nervous Disorders	Y	N	20.	Arthritis	Y	N
6.	Visual Problems	Y	N	21.	Back Pain or Injury	Y	N
7.	Hearing Problems	Y	N	22.	Joint Pain or Injury	Y	N
8.	Shortness of Breath	Y	N	23.	Broken Bones	Y	N
9.	Chronic Pain	Y	N	24.	Allergies	Y	N
10.	Emphysema	Y	N	25.	Diabetes	Y	N
11.	Asthma	Y	N	26.	Tumor(s)	Y	N
12.	High Blood Pressure	Y	N	27.	Hepatitis	Y	N
13.	Chest Pain	Y	N	28.	Tuberculosis	Y	N
14.	Heart Problems	Y	N	29.	Alcohol Problems	Y	N
15.	Skin Problems	Y	N	30.	Drug Problems	Y	N

Family History: ☐ Diabetes ☐ High Blood Pressure ☐ Strokes ☐ Cancer ☐ Heart Disease ☐ Seizures

Please Explain Family History if marked: ______________________

Do You Smoke? ☐ NO ☐ YES, How Much __________

Previous Injuries/Accident: ______________________ Body part injured: __________
Date: __________

For Female Patients: *Date of Last Menstrual Period* __________ ***Difficulties with Cycle:*** ☐ ***Yes*** ☐

CURRENT MEDICAL

Please list any medications you may be taking at this time: ______________________

____

____

Current Complaints at this time: ☐ Head ☐ Neck ☐ Mid Back ☐ Upper Back ☐ Low Back ☐ Shoulder R L ☐ Elbow R L ☐ Wrist R L ☐ Hand R L ☐ Finger/Thumb ☐ Chest ☐ Ribs ☐ Abdomen ☐ Pelvic ☐ Tail Bone ☐ Hip R L ☐ Thigh R L ☐ Knee R L ☐ Calf / Chin R L ☐ Ankle R L ☐ Foot R L ☐ Toe __________

Any previous history of the above complaints? ☐ YES ☐ NO
Please Describe: ______________________

____

Any previous treatment for the above complaints? ☐ YES ☐ NO
Please Describe: ______________________

____

If you did not receive medical treatment for this injury within one week, please provide a reason for delay: __________

____

____

PATIENT: ______________________	SOCIAL SECURITY: ______________________

ACTIVITIES OF DAILY LIVING

** To be completed by PATIENT*

This questionnaire is to give your Doctor information as to how your pain has affected your ability to manage everyday life. ***Please check which item closely describes your current situation.***

Section 1 PAIN INTENSITY

☐ I can tolerate the pain without painkillers.
☐ The pain is bad, but I manage without painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers give no relief and I do not use them.

Section 2 PERSONAL CARE

☐ I can look at myself without causing extra pain.
☐ I can look at myself, but it causing extra pain.
☐ It is painful to look at myself. I am slow and careful.
☐ I need some help, but manage most of my personal care.
☐ I need help every day in most of my personal care.
☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 LIFTING

☐ I can lift heavy weight without extra pain.
☐ I can lift heavy weight, but with extra pain.
☐ Pain prevents me from lifting heavy weight off floor, but can manage from table level.
☐ Pain prevents me form lifting heavy weight, but I can manage light to medium weight.
☐ I can only lift very light weight.
☐ I can not lift or carry anything.

Section 4 WALKING

☐ Pain does not prevent me form walking any distance.
☐ Pain prevents me from walking more than 1 mile.
☐ Pain prevents me from walking more than ½ mile.
☐ Pain prevents me from walking more than ¼ mile.
☐ I can only walk using a walker, cane, or crutches.
☐ I am in bed most of the time and have to crawl to toilet.

Section 5 SITTING

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chain as long as I like.
☐ Pain prevents me from sitting for more than 1 hour.
☐ Pain prevents me from sitting for more than 30 minutes.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting at all.

Section 6 STANDING

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want, but it causes extra pain.
☐ Pain prevents me from standing for more than 1 hour.
☐ Pain prevents me from standing for more than 30 minutes
☐ Pain prevents me from standing for more than 10 minutes
☐ Pain prevents me form standing at all.

Section 7 SLEEPING

☐ Pain does not prevent me from sleeping
☐ I can sleep well only if I use medication.
☐ Even when I take medication, I sleep less than 6 hours
☐ Even when I take medication, I sleep less than 4 hours.
☐ Even when I take medication, I sleep less than 2 hours.
☐ Pain prevents me from sleeping at all.

Section 8 SEX LIFE

☐ My sex life is normal and causes no extra pain.
☐ My sex life is normal, but causes extra pain.
☐ My sex life is nearly normal, but is very painful.
☐ My sex life is severely restricted by pain
☐ My sex life is nearly absent because of pain.
☐ Pain prevents any sex life at all.

Section 9 SOCIAL LIFE

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal, but increases my pain.
☐ Pain has no significant effect on my social life, but limits more energetic activities (dancing, etc)
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home only.
☐ I have no social life because of the pain.

Section 10 DRIVING

☐ I can drive anywhere without extra pain.
☐ I can drive anywhere, but it gives me extra pain.
☐ Pain is bad, but I manage over 2 hours.
☐ Pain restricts me from driving less than 1 hour.
☐ Pain restricts me to short trips, less than 30 minutes.
☐ Pain restricts me from driving. I have rides to places.

PAIN QUESTIONNAIRE and DUTIES UNDER DURESS

NAME: ______________________________ DATE: ______________

Prior to coming to this office, did you have pain while conducting your daily activities? ☐ YES ☐ NO
If so, please answer the following: *Please check all that apply.*

1. Did you continue to work despite pain? ☐ YES ☐ NO

   ☐ Thought you would lose your job.
   ☐ Personal work ethic.
   ☐ Couldn't otherwise support your family.
   ☐ Co-workers / Clients need you.
   ☐ Other: ______________________________

2. Did you continue to do domestic work despite pain? ☐ YES ☐ NO

   ☐ Laundry. ☐ Taking out trash. ☐ Child Care: ______________
   ☐ Dishwashing. ☐ Dusting ☐ Adult Care: ______________
   ☐ Vacuuming. ☐ Disinfecting, toilets, etc. ☐ Other: ______________
   ☐ Making Beds. ☐ Mopping ______________

3. Did you continue to do house work or hobbies despite pain? ☐ YES ☐ NO

   ☐ Painting the house. ☐ Raking Leaves ☐ Gardening
   ☐ Landscaping. ☐ Cleaning garage ☐ Hobbies: ______________
   ☐ Mowing the lawn. ☐ Hand wash vehicles ______________
   ☐ Other: ______________________________

4. Did you continue with your studies work despite pain? ☐ YES ☐ NO

   ☐ Carry your books. ☐ Study ☐ Computer activity
   ☐ Sit through classes. ☐ Research ☐ Writing papers / homework
   ☐ Other: ______________________________

As of today, what activities ***could*** you do BEFORE the accident that you COULD NOT do AFTER the accident? Please Explain.

☐ Sports: ______________ ☐ Child / Family: ______________
☐ Exercise: ______________ ______________
☐ Work: ______________ ______________
☐ Home: ______________
☐ Social: ______________

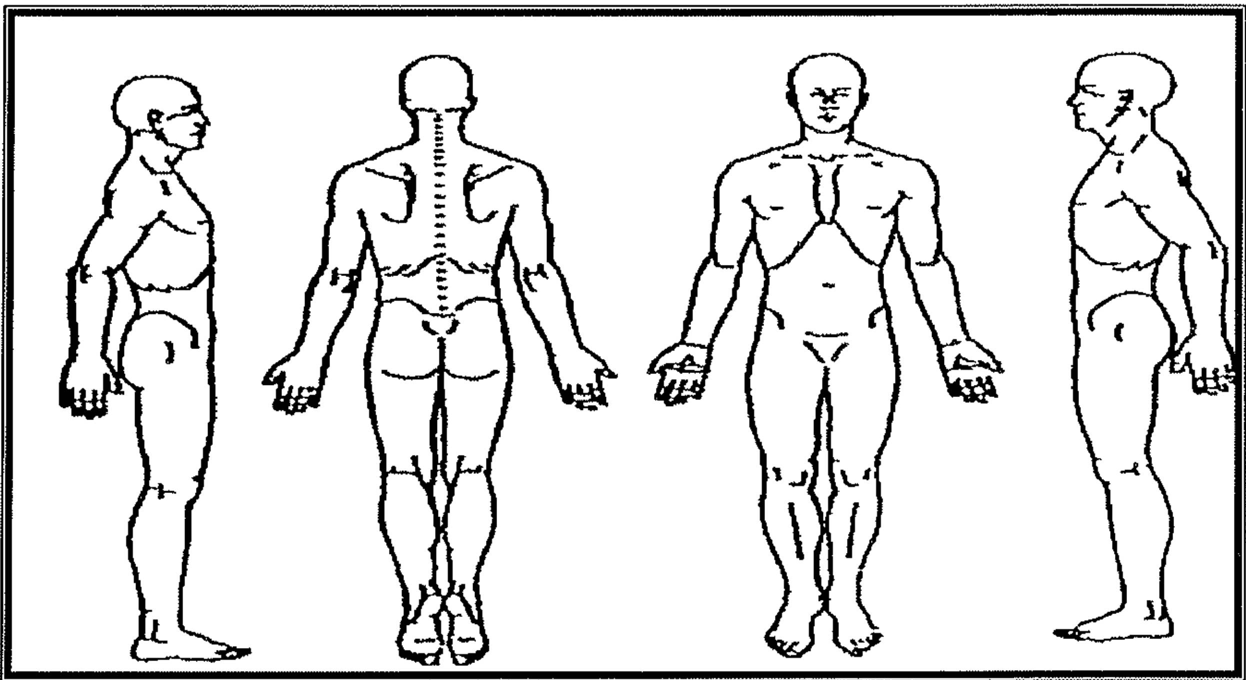
What activities ***did*** you do AFTER the accident and BEFORE you came to this office that caused you pain? Please Explain.

☐ Sports: ______________ ☐ Child / Family: ______________
☐ Exercise: ______________ ______________
☐ Work: ______________ ______________
☐ Home: ______________
☐ Social: ______________

NAME: ______________________________ DATE: ______________

PLEASE USE THE FOLLOWING DRAWING TO ACCURATELY MARK THE AREAS IN WHICH YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOLS AND INCLUDE ALL AFFECTED AREAS.
Por favor use los simbolos en el siguiente dibujo para demonstrar la area que esta afectada.

Dull: DDDDD **Agudo**	**Stabbing/cutting**: ///// **Cortaduras**	**Burning**: XXXX **Quemaduras**
Numb: NNNN **Dormido**	**Tingling**: TTTT **Cosquillas**	**Cramping**: SSSS **Calambres**



Please place a circle on the line below to indicate your present pain level
Por favor circule el nivel de dolor que le corresponde

MILD Minimo **MODERATE** Moderado **INTENSE** Intenso

No Pain 1------2------3------4------5------6------7------8------9------10 Worst Pain

PATIENT SIGNATURE: ______________________________
Firma de paciente