Date:_____

Galveston Physical Medicine
2724 61st Ste # 5
Galveston, TX 77551

Name: _____
ID: _____/_____/_____

KNEE CONSULTATION QUESTIONNAIRE

Womac Osteoarthritis Index

Pain: The following questions concern the amount of pain you are currently experiencing in your knees. Indicates the level of pain associated with:

	None	Mild	Moderate	Severe	Extreme
1. Walking on flat surface	0	1	2	3	4
2. Up or Down Stairs	0	1	2	3	4
3. At night while in bed	0	1	2	3	4
4. Sitting or Lying	0	1	2	3	4
5. Standing Upright	0	1	2	3	4

Stiffness: 1.) How severe is your stiffness after first awakening in the morning?

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

2.) How severe is your stiffness after sitting, lying, or resting later in the day?

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

Physical function: The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. What degree of difficulty do you have with:

	None	Mild	Moderate	Severe	Extreme
1. Descending Stairs	0	1	2	3	4
2. Ascending Stairs	0	1	2	3	4
3. Rising from sitting	0	1	2	3	4
4. Standing	0	1	2	3	4
5. Bending to the floor	0	1	2	3	4
6. Walking on a flat surface	0	1	2	3	4
7. Getting in/out of car	0	1	2	3	4
8. Going shopping	0	1	2	3	4
9. Putting on socks	0	1	2	3	4
10. Rising from bed	0	1	2	3	4
11. Taking off socks	0	1	2	3	4
12. Lying in bed	0	1	2	3	4
13. Getting in / out of bath	0	1	2	3	4
14. Sitting	0	1	2	3	4
15. Getting on /off toilet	0	1	2	3	4
16. Heavy duties (moving)	0	1	2	3	4
17. Light duties (cleaning)	0	1	2	3	4

Patient Registration Form

Galveston Physical Medicine

2724 61st #5

Galveston, Texas 77551

Office: 409-744-9355 • Fax: 409-744-9356

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

S.S.N.: _____ Date of Birth: _____ Age: _____

Gender: Male □ Female □ Email Address: _____

Marital Status: Married □ Divorced □ Single □ Widowed □

Referring Physician: _____ Reason for your visit? _____

Phone: ( ) _____

Address: _____
Street City State Zip Code

Employer or School: _____ Address: _____

Emergency Contact: _____ Relation: _____ Phone: ( )_____

Spouse's Name: _____ S.S.N.: _____

Spouse's Date of Birth: _____ Employer: _____

Spouse's Phone: ( ) _____ Are you insured under their policy? Yes □ No □

Responsible Party Name and Address (Under 18):

Relation to Patient: _____

Date of Birth: _____ Employer: _____ Phone: ( ) _____

Health/Medical Insurance □ Yes □ No □ Self-Pay

PATIENT INSURANCE INFORMATION TO BE COMPLETED ON PATIENT INSURANCE FORM ATTACHED

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

Signature: _____ Date: _____

Galveston Physical Medicine

Authorization for Release of Information

Patient Name: _____ DOB: ___/___/___SSN: ____-____-____

Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

I authorize: _____

Physician Name Facility Name Facility Phone

_____

Facility Address Facility Fax

To send/release photocopies of medical records concerning the above named person to:

Galveston Physical Medicine
2724 61st #5
Galveston, Texas 77551

For the purpose of treatment for _____. I authorize the release of photocopies of the following medical records and information in their possession including all confidential HIV related information, confidential alcohol or drug abuse related information and confidential mental health diagnosis and treatment information. I agree that these provisions will remain in effect until I provide written revocation to Galveston Physical Medicine.

☐ Medical Records ☐ Hospital Records ☐ Procedure Records ☐ Laboratory Records

_____ Inpatient _____ Outpatient ☐ Other

_____ _____ _____

Signature of Patient/Legal Guardian Relationship to Patient Date

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AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse and HIV or communicable disease) requested by my health insurance carrier, Medicare or any other third-party payers, and I authorize Galveston Physical Medicine to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Galveston Physical Medicine.

I agree that these provisions will remain in effect until I provide written revocation to Galveston Physical Medicine.

_____ _____ _____

Signature of Patient/Legal Guardian Relationship to Patient Date

Galveston Physical Medicine

Patient Consent Form

I, _____, understand that as part of my health care, that Galveston Physical Medicine creates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I acknowledge that I have been provided with a *Notice of Privacy* which provides a more completes description of information uses and disclosures.

I understand that Galveston Physical Medicine is not required to agree to the restrictions requested and that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Federal and State Regulations.

I further understand that Galveston Physical Medicine reserves the right to change their notice and practices and prior to implementation, in accordance with Federal and State Regulations.

Galveston Physical Medicine has my consent to give out my private health information, including my identity, diagnoses and treatments, whether in writing or verbally, to the following persons or entities (e.g. spouse, child or other representative):

_____

Name Relationship to Patient

_____

Name Relationship to Patient

_____

Name Relationship to Patient

I understand that as require for Galveston Physical Medicine's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient or Guardian Witness

_____ _____

Date Date

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**)_____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

_____

Please list any allergies: _____

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

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

Reviewed by Provider:_____(initials)