PHYSICAL MEDICINE ASSOCIATES OF N.W. OHIO, INC.

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Phone: 419-228-5434 Fax: 419-228-4620

Kurt A. Kuhlman, D.O. ***Xavier D. DiSabato, D.O.***

Jodi M. Wilhelm, C.N.P. ***Kathy M. Harvey, C.N.P.*** ***Vicki S. Casey, C.N.P.***

We want to welcome you as a new patient, and
give you some information about our practice.

The Providers: Dr. Kurt Kuhlman is Board Certified in Physical Medicine and Rehabilitation, in electrodiagnostic medicine, and is an Independent Medical Examiner. Dr. Xavier DiSabato is an osteopathic neuromusculoskeletal medicine specialist. Jodi Wilhelm, Kathy Harvey and Vicki Casey are certified nurse practitioners with advanced training in neuromuscular disorders. Our primary emphasis is to thoroughly evaluate and accurately diagnose and treat problems that may be related to pain, numbness, weakness, loss of motion and difficulty walking. However, our team members also have advanced skills with everything listed in the treatment options below. All five providers have specialized areas of interest and expertise. We work together as a team and you may see more than one provider depending on your unique medical condition.

EMG/NCS (electromyography/nerve conduction studies) is a test designed to evaluate and diagnose muscle and nerve problems. Specifically, it can help determine what is causing your pain, weakness, numbness and/or difficulty walking. EMG involves placing a small pin just under the skin into your muscles. NCS involves evaluation of various nerves with a small electrical stimulation and wires taped to the skin. **PLEASE DO NOT USE LOTIONS, MOISTURIZERS OR POWDERS THE DAY OF TESTING. YOU WILL NOT REQUIRE A DRIVER IF YOU HAVE EMG/NCS.**

Ultrasound is a very detailed picture of your body. Unlike an MRI, it can be performed when you are moving to more accurately evaluate the function of your muscles, tendons, ligaments, bones, joints, blood vessels and nerves. It can be used to accurately diagnose a wide variety of conditions. Ultrasound can also be used to guide the needle when performing injections to make sure the medication is accurately placed in the correct location.

What to expect: We will thoroughly review your pertinent medical history. **PLEASE BRING A LIST OF YOUR CURRENT MEDICATIONS (prescribed, vitamins, minerals, herbs, over the counter) AND DOSAGES ALONG WITH ANY X-RAY STUDIES (CT/MRI)** that are related to the problem we are evaluating. Expect to have a "hands-on" physical examination including evaluation of your strength, sensation, reflexes, posture, range of motion and gait. We will then review your specific diagnosis and treatment options with you. Frequently, we will have handouts available that detail your medical condition. A very thorough report will then be sent to your referring physician, and any other provider you wish it sent to.

Treatment options: If your provider requests that we manage your medical condition, we provide a wide variety of treatments such as oral and topical medications, migraine management, Botox injections, trigger point injections with ultrasound guidance, prolotherapy, PRP, nerve hydrodissection, acupuncture, osteopathic manipulative therapy, exercise recommendations, orthotics, weight loss, antiaging medicine, bioidentical hormone replacement, intravenous treatments, osteoporosis management, nonsurgical cosmetic treatment, etc. Additionally, we can give you recommendations on other medical specialists and therapists who may be able to help you.

Appointments: Please contact the office if you are going to be late for your appointment or if you need to change your appointment. We try to give each patient as much time as needed for their particular problems. Therefore, on occasion, your exam, or the exam of your fellow patients may take longer than expected. We greatly appreciate your patience during these times. **We will be charging a $50.00 no show fee if you do not call within 24 hours of the appointment. This must be paid before your next scheduled visit or you will be unable to see the physician.**

Insurance: Please bring your insurance cards for primary and secondary (if applicable) and any co-pays required. If your card has a copay amount on it and is current, that is what will be collected. If an amount comes up when our staff puts information in, that is what will be collected. The patient can call their insurance and ask about potential copay. **ALL COPAYS ARE DUE AT THE TIME OF SERVICE. If you do not pay your copay, you will be unable to see the physician until it is paid.**

Please make sure to list your employer on the attached form in case further treatments need approved. We are in network with a wide variety of insurances. If there is any question that we participate with your insurance, please contact your insurance to verify.

We do not bill auto insurance, attorneys or organizations that pay for medical care. Therefore, it will be considered self pay and the patient is responsible for payment of our services at the time of service and we will provide claim information or receipt to take to the third party.

Proof of Identity: Please bring a valid picture ID to your appointment so we can help in prevention of identity theft.

We hope this has been helpful. We will see you on:

_____ DAY

_____ DATE

_____ ARRIVAL TIME

_____ APPOINTMENT TIME

PHYSICAL MEDICINE ASSOCIATES OF N.W. OHIO, INC.

NEW PATIENT REGISTRATION

(Please Print)

Patient Name _____

□ Male □ Female □ Other

Marital Status
□ S □M □W
□ D □ SEP □ Other

Date of Birth / /

Age

Social Security #

ETHNIC GROUP
Hispanic/Latino
□ Yes □ No

RACE
□ White □ Black/African American
□ Asian □ Multiracial □ Other

PREFERRED LANGUAGE
□ English
□ Spanish □ Other

Patient Street Address _____ **City and State** _____ **Zip Code** _____

(_____)_____ **Home Phone**

(_____)_____ **Cell Phone**

□ Yes □ No **Text Reminder**

Email Address (please provide even if you do not use as it counts toward Government requirement for physicians) _____

Preferred Pharmacy Name _____ **Location** _____

Patient's Employer _____ **Occupation** _____ **How Long Employed?** _____ (_____)_____ **Employer Phone**

Spouse or Parent's Name _____ **Date of Birth** _____ **Social Security #** _____

Spouse or Parent's Employer _____ **Occupation** _____ **How Long Employed?** _____ (_____)_____ **Employer Phone**

INSURANCE INFORMATION

Bring your insurance card to every appointment with you. If this is Workers' Compensation injury, bring your Workers' Comp. card.

Accident?
□ Yes □ No

Workers' Comp. Injury?
□ Yes □ No

Date of Accident / /

Claim # -

Were x-rays taken of this injury or problem?
□ Yes □ No

If yes, when and where were x-rays taken (hospital, etc.) _____

Referred by _____ **Street address, City, State and Zip Code** _____ (_____)_____ **Phone**

Family Doctor _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I hereby authorize Physical Medicine Associates of N.W. Ohio, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ **Date:**_____ **Signature:** _____ **Date:**_____

Signature: _____ **Date:**_____ **Signature:** _____ **Date:**_____

TELEPHONE (CELL PHONE) CONSUMER PROTECTION ACT AUTHORIZATION

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated message, email, test messaging, or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Date: _____ Signature: _____

PHYSICAL MEDICINE ASSOCIATES OF N.W. OHIO, INC.

MEDICAL HISTORY

Patient Name_____ Age _____ DOB: _____
Referring Physician _____Family Physician _____

What is the main problem that brought you to the doctor today? _____
_____
_____
Have you had any tests? _____
Have you had any treatment? _____

MEDICAL HISTORY (date started):

- ☐ Headaches _____
- ☐ Stroke _____
- ☐ Seizures _____
- ☐ Pneumonia _____
- ☐ Diabetes _____
- ☐ Thyroid Disease _____
- ☐ Vision Loss _____
- ☐ Hearing Loss _____
- ☐ High Blood Pressure _____
- ☐ Blood Clots _____
- ☐ Heartburn _____
- ☐ Stomach Disease/Ulcers_____
- ☐ Heart Disease _____
- ☐ High Cholesterol _____
- ☐ Liver Disease _____
- ☐ HIV/AIDS _____
- ☐ Chronic Back Pain _____
- ☐ Multiple Sclerosis _____
- ☐ Broken Bones/Fractures _____
- ☐ Other _____

- ☐ Cancer _____
- ☐ Sleep Apnea _____
- ☐ Kidney Stones _____
- ☐ Lung Disease _____
- ☐ Asthma _____
- ☐ Depression _____
- ☐ Bipolar Disorder _____
- ☐ Anxiety _____
- ☐ Fibromyalgia _____
- ☐ Chronic Fatigue Syndrome _____
- ☐ Arthritis _____
- ☐ Gout _____
- ☐ Osteoporosis _____
- ☐ Prostate Disease _____
- ☐ Breast Disease _____
- ☐ Erectile Dysfunction _____
- ☐ Brain Injury _____
- ☐ MRSA/VRE _____
- ☐ Polio _____

SURGICAL HISTORY (indicate date if known):

- ☐ None
- ☐ Cataracts _____
- ☐ LASIK _____
- ☐ Tonsillectomy _____
- ☐ Thyroidectomy _____
- ☐ Adenoidectomy _____
- ☐ Coronary Bypass _____
- ☐ Cardiac Stents _____
- ☐ Pacemaker/Defibrillator_____
- ☐ Heart Valve _____
- ☐ Gall Bladder _____
- ☐ Appendectomy _____

- ☐ Bowel/Stomach Resection _____
- ☐ Hemorrhoidectomy _____
- ☐ Bariatric surgery _____
- ☐ Hysterectomy _____
- ☐ Hernia Repair_____
- ☐ Neck/Back Surgery_____
- ☐ Bladder Surgery _____
- ☐ Prostate surgery/resection _____
- ☐ C-Section _____
- ☐ Orthopedic/joints _____

_____

- ☐ Other _____

Please list all of your **CURRENT MEDICATIONS** (Continue listing on back of page if needed)
PLEASE INCLUDE ALL HERBS, VITAMINS, MINERALS AND OVER THE COUNTER MEDICATIONS

Medication Name	Dosage (Mg)	Prescribed by (Name/ Specialty)

ALLERGIES: (Medication/Food, indicate reactions): ☐ None known

SOCIAL HISTORY:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Domestic Partner

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Laid Off

Current Occupation _____ Former Occupation _____

Education Level: _____ School: _____

Children (Age): _____

Hobbies: _____

Alcohol: ☐ None ☐ Yes: How many drinks/week _____ What kind (beer, wine, etc.)_____

Tobacco: ☐ None ☐ Yes: What kind? _____ How much?_____ Started? _____ Quit?_____

How many glasses/cups/cans of caffeine (pop, coffee, tea) do you drink daily? _____

Do you exercise? ☐ Yes ☐ No If yes, how much? _____

Are you right or left handed? _____ Pets? _____

FAMILY HISTORY: Do any medical problems run in your immediate family? (PLEASE INDICATE WHO)

- □ None
- □ Diabetes _____
- □ Heart Disease_____
- □ Cancer/Type_____
- □ Thyroid_____
- □ Bleeding_____
- □ Stroke_____
- □ High Cholesterol_____
- □ High Blood Pressure_____
- □ COPD/Emphysema_____
- □ Arthritis_____
- □ Depression/Anxiety_____
- □ Autoimmune Disease/Type_____
- □ Other_____

REVIEW OF SYSTEMS: Do you have any of the following symptoms (please check yes or no for each)

GENERAL	Fever	□ No	□ Yes	Night Sweats	□ No	□ Yes
HEAD	Dizziness	□ No	□ Yes	Vision Loss	□ No	□ Yes
	Hearing Loss	□ No	□ Yes	Difficulty Swallowing	□ No	□ Yes
	Seizures	□ No	□ Yes	Fainting	□ No	□ Yes
BLOOD	Easy Bruising	□ No	□ Yes	Easy Bleeding	□ No	□ Yes
GLANDS	Weight Gain or Loss	□ No	□ Yes	Excessive Thirst	□ No	□ Yes
SKIN	Rash	□ No	□ Yes	Hair Loss	□ No	□ Yes
HEART	Chest Pain	□ No	□ Yes	Shortness of Breath	□ No	□ Yes
	Irregular Heart Beat	□ No	□ Yes	Ankle Swelling	□ No	□ Yes
LUNGS	Cough	□ No	□ Yes	Wheezing	□ No	□ Yes
STOMACH/INTESTINES	Constipation	□ No	□ Yes	Diarrhea	□ No	□ Yes
	Blood in Stools	□ No	□ Yes	Nausea/Vomiting	□ No	□ Yes
	Stomach Ulcers	□ No	□ Yes	Loss of Bowel Control	□ No	□ Yes
GENITALS/URINARY	Prostate Problems	□ No	□ Yes	Problems with Urinating	□ No	□ Yes
	Problems with Sex	□ No	□ Yes	Loss of Bladder Control	□ No	□ Yes
MENTAL	Anxiety	□ No	□Yes	Depression	□ No	□ Yes
NERVE/MUSCLE/JOINT	Joint Stiffness	□ No	□ Yes	Joint Swelling	□ No	□ Yes
	Muscle Pain	□ No	□ Yes	Muscle Weakness	□ No	□ Yes
	Chronic Widespread Pain	□ No	□ Yes	Difficulty Sleeping	□ No	□ Yes
	Chronic Fatigue	□ No	□ Yes	Tingling Sensations	□ No	□ Yes
	Worse with Cold Weather	□ No	□ Yes	Headaches	□ No	□ Yes
	Family Member with Fibromyalgia	□ No	□ Yes	Jaw Pain/TMJ	□ No	□ Yes

Patient/Guardian Signature: _____ **Date** _____

UPDATED: Signature: _____ Date _____

UPDATED: Signature: _____ Date _____

UPDATED: Signature: _____ Date _____

BRIEF PAIN INVENTORY

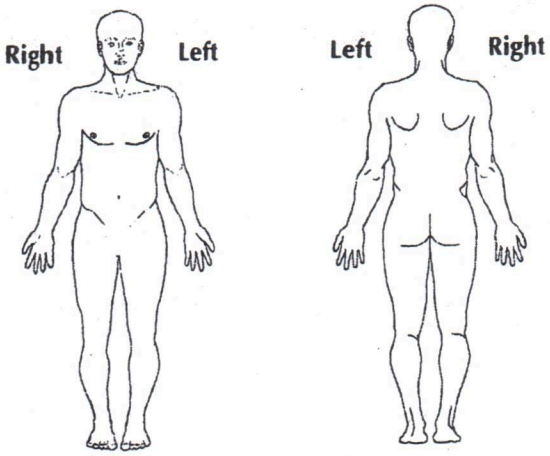
Date_____/_____/_____ Time:_____

Name:_____ _____ _____
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0% 10 20 30 40 50 60 70 80 90 100%

No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Brief Pain Inventory (Short Form). Source: Pain Research Group, Department of Neuro-Oncology. The University of Texas MD Anderson Cancer Center. Used with permission. Adapted to single page format.

In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please tell us:

What does the pain feel like? Circle those words that describe your pain.

aching	throbbing	shooting
stabbing	gnawing	pricking
sharp	tender	burning
exhausting	tiring	penetrating
nagging	numb	miserable
unbearable	dull	radiating
squeezing	cramping	deep

How long have you had this pain? (Circle one)

less than a week	1 to 2 weeks
2 to 4 weeks	more than a month

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

What kinds of things make your pain worse (for example, walking, standing, lifting)?

_____

_____

Do you have any other symptoms? Circle any that apply:

nausea	vomiting
constipation	diarrhea
lack of appetite	indigestion
difficulty sleeping	feeling drowsy
nightmares	dizziness
tiredness	itching
urinary problems	sweating
weakness	headaches

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why Is Pain Relief So Important?

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Controlled

It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain.

The key to effective pain control is to take the RIGHT AMOUNT, of the RIGHT MEDICINE, at the RIGHT TIME. You should take your pain medicine on a regular schedule, as your doctor, nurse, or pharmacist tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild than when it has reached full force.

If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

Comments: Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.

_____

_____

_____

_____

_____

_____

Provided as an educational service by ENDO PHARMACEUTICALS

PM-0033R/September, 2004

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AUTHORIZATION TO RELEASE PERSONAL HEALTH CARE INFORMATION

While we have instituted the new formal policies required by HIPAA, we have always taken the protection of personal information very seriously. You may note some changes in the information that will be available as a result of the new requirements. For instance, we will no longer be able to provide information to a spouse or family member calling for information regarding your personal health care, including test results, without a written authorization from the patient. We regret the inconvenience of this new policy, but we are prohibited from releasing that information without an authorization from the patient.

List who you would like us to release your information to:

NAME **RELATIONSHIP** **PHONE NUMBER**

_____

_____

_____

_____

(circle one)

Starting date: _____ good until: 1 yr. 5yrs. Life or other date: _____

Patient Printed Name: _____

Patient Signature:_____Date:_____

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name: _____

Patient Signature: _____Date:_____