NEAL ALPINER M.D. FAAP, FAAPMR, CLCP
355 Barclay Circle, Suite A
Rochester Hills, MI 48302
Ph 877-433-7767 Fax 877-433-6907
Board Certified Pediatrics, Board Certified PM & R

NEW PATIENT CONSENT AND HISTORY FORMS

- **I acknowledge that I have read and agreed to the Confidentiality Release. You may release my information to the following individuals (other than referring physician office)**

_____

- **I have received a copy of the office's Notice of Privacy Practices Form or acknowledge having read them.**
- **I acknowledge and agree to The Alpiner Group Consent for Treatment.**
- **I acknowledge that it is my responsibility to notify Dr. Alpiner's staff of dates that tests have been taken so that results may be properly followed up.**
- **I agree to receive emails or text messages from The Alpiner Group. Message and data rates may apply. Text STOP to unsubscribe from messages at any time.**
- **I have read, understand and agree to The Alpiner Group Financial Policies as described above.**
- **I have read, understand and agree to all policies and terms of The Alpiner Group.**

Patient Name _____

Guarantor or Guardian (Relationship to Patient) _____

Date _____

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NEW PATIENT INFORMATION

Date _____ Name: _____ DOB: _____ Age _____ Sex: M F

Who referred you to our office for care? _____

The reason for today's office visit is: _____ Chief Complaint_____

What tests have you had for this problem? _____

Did you sustain an injury or trauma? Y N Date of Injury _____

Is there a lawsuit pending or anticipated in this case? Y N Filing for disability? Y N

Patient treated at hospital for this condition? Y N When? Where?

Physicians you have seen for this problem _____Approximate Date treated_____

Past Medical History

Other medical problems _____
Surgeries and Dates _____
Previous Accidents _____
Current Medications _____
Allergies to Medications _____

Other problems: Review of Symptoms **PLEASE PUT NOTE IF YOU HAVE ANY OF THE FOLLOWING**

Head	Bladder	Psychiatric
Throat	Bowel	Weight Gain
Chest	Fevers/Chills	Weight Loss
Heart	Muscles	Appetite
Abdomen	Bones	Blood
Skin	Endocrine Glands	

Concussion, Head Injury, Seizures, Migraines/Headaches, Pain Syndromes, Autism/Spectrum Disorders, Muscle Weakness, Hypotonia, Cerebral Palsy, Torticollis, Gait Disturbance, Other_____

Behavioral (circle all that apply)

ADD/ADHD, Depression, Anxiety, Bipolar, Personality Disorder, Other_____

Has patient had any behavioral/counseling therapy previously?

Provider name: _____ Date of Treatment _____

General Medical (circle all that apply)

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Obesity, Asthma, Heart Disease/Congenital Heart Disease, Arthritis, Diabetes, Colic, Cancer/Oncologic

Other _____

HISTORY OF PRESENT PAIN (if applicable):

How long has patient noticed the pain?

____Days _____Weeks ____Months _____Years

Rate USUAL pain: **WHAT NUMBER IS YOUR PAIN**

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

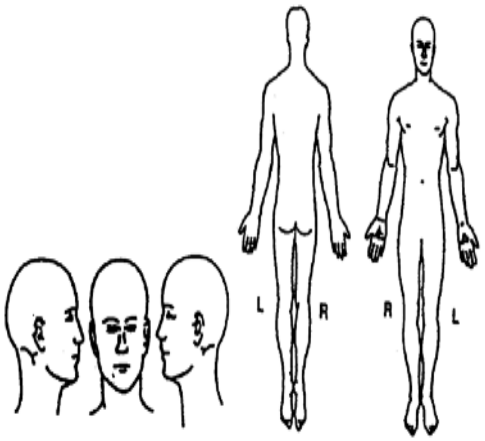
Describe pain: **WHAT TYPE OF PAIN ARE YOU EXPERIENCING**

Burning, Tingling, Numbness, Pinprick, Stabbing, Deep-Pressure, Tightness, Spasms

Any prior injury or pain before the event above? Please describe.

Have you seen a specialist concerning this pain prior? Please indicate specialist and date if seen.

_____



PAIN (if applicable)
Has the patient had therapy or treatment related to this condition previously?

Physical Therapy **Occupational Therapy**

Speech Therapy **Other_____**

PLEASE LIST LOCATION AND DATE OF ANY OF THE FOLLOWING;

If yes, when and where test performed?

X-Ray	MRI	CT	EMG	Bone Scan	Laboratory	Other

IF THE PATIENT HAD A CONCUSSIVE/HEAD/BRAIN INJURY:

Are you currently experiencing any of the following (LIST OR PUT "X" NEXT TO ANY THAT APPLY):

Dizziness	Headaches	Nausea	Vertigo
Loss of Balance	Concentration Issues	Visual Disturbance	Sound/Light Sensitivity

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Difficulty Reading	Mood Changes	Academic Struggles	Other(Please Explain)

PREVIOUS MEDICATIONS PRESCRIBED OVER PAST TWO YEARS

Name of Medication	Dosage

FAMILY HISTORY:

Please list any major medical conditions that your Mother, Father, Maternal/Paternal Grandparents, Aunts, Uncles and Siblings may have

Relationship	Diagnosis

SOCIAL HISTORY

Primary language spoken in home

Who lives in home with patient?

Please check if appropriate

- Tobacco/smoke use
- Tobacco/smoke exposure
- Substance abuse
- Exercise regularly
  - If yes, how often _____

OTHER MEDICAL HISTORY
Please notify this office of any prior relevant medical history. Please inform of any outside health encounters.

PEDIATRIC PATIENTS (Adult patients do not need to complete)
Developmental History:

Not Delayed Delayed Other (explain)

School Name: _____ Current Grade _____

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Attendance (circle) Good Fair Poor
Performance/Grades A B C D E
History of Learning Disability YES NO
Other activities outside of school? _____

Safety:

- Seat belt use
- Helmet use