ProHealth Physical Medicine
Studio City, CA 91604

Date: _______________________ Patient Name_____________________________________ D.O.B.______________________
SS #/SIN_______________________ ☐ Male ☐ Female Home phone_____________________
E-Mail ____ Cell Phone ________________ Carrier _______________

Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's or parent/guardian's employer ________________________________ work phone __________________________
Address ____City _______________ State______ Zip__________________________
Business Address ____ City____________________ state _____ Zip __________
Spouse or parent/guardian's name______________________ Employer_____________________ work phone___________________
Business Address____City__________________________State_____Zip__________
Spouse or Parent/Guardian's name______________________________ Employer __________________ Work Phone___________
If Patient is a student, name of school/college____City__________________State_____
Whom may we thank for referring you? ____
Person to contact in case of an emergency__________________________________ Phone______________________________
In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

____ ______________________________
Parent or Guardian Date

Responsible Party
Name of The Person responsible for this account ________________________Relationship to Patient _____________________
Address ____Home Phone _____________________________
E-Mail ____Cell Phone ______________________________
Driver's License # __________________________ Date of Birth: ____
Employer ____Work Phone_____________________________

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any additional insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured____ Relationship to patient__________________________
Birthdate______________________ SS#/SIN_____________________________ Date employed________________________________
Name of Employer____ Work Phone ____
Address of Employer____ State ____________ Zip/P.C______________________________
Insurance Company______________________________ Group #__________________ Union or local # ____________________________
Ins. Co. Address _____________________________________ City _________________ State _________ Zip________________________
How much is your deductible? _________________ how much have you used? _________________

Assignment and Release

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Boulevard Medical Group, Prohealth Physical Medicine, and/or Dr. Robert Gonzalez as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

X____ ______________________________
Signature of Patient or parent/guardian of minor Date

Health History

Patient Name: ___________________________DOB: __________________Date:____________

Chief Complaint: ____

History of Present illness:

Location: ____
(Where is the pain/problem?)

Quality: ____
(Example: normal vs abnormal color, activity, etc..)

Severity: ____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration: ____
(How long have you had this Pain/ problem? when did it start?)

Timing: ____
(Does the pain/problem occur at a specific time?)

Context: ____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _________________________
____
(what other associated problems have you been having?)

modifying factors __________________________________
____
(What makes the pain/problem worse or better? Have you Had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no" leave blank if you are uncertain.)

Measles…………… NO YES	Anemia………………….NO YES	Back Trouble………………NO YES	Hepatitis……………………NO YES
Mumps…………… NO YES	Bladder infection…….NO YES	High Blood Pressure……NO YES	Ulcer……………………………NO YES
Chicken Pox……… NO YES	Epilepsy……………………NO YES	Low Blood pressure…….NO YES	Kidney Disease……………NO YES
Whooping Cough… NO YES	Migraine Headaches. NO YES	Hemorrhoids………………NO YES	Thyroid Disease…………NO YES
Scarlet Fever………. NO YES	Tuberculosis…………….NO YES	Date of Last chest X-Ray_____________	Bleeding Tendency…….NO YES
Diphtheria…………… NO YES	Diabetes………………….NO YES	Asthma……………………….NO YES	Any Other Disease…….NO YES
Small pox……………. NO YES	Cancer……………………..NO YES	Hives of Eczema………….NO YES	(Please List):
Pneumonia…………. NO YES	Polio…………………………NO YES	AIDS & HIV……………………NO YES	
Rheumatic Fever… NO YES	Glaucoma…………………NO YES	Infectious Mono……………NO YES	______________________________
Arthritis………………. NO YES	Hernia………………………NO YES	Bronchitis……………………..NO YES	
Venereal Disease… NO YES	Blood or Plasma Transfusion…………….NO YES	Mitral Valve Prolepses….NO YES	______________________________
		Stroke……………………………NO YES	

Previous Hospitalizations/surgeries/serious illnesses When? Hospital, City, State

Previous Hospitalizations/surgeries/serious illnesses	When?	Hospital, City, State
____	____________________	__________________________
____	____________________	__________________________
____	____________________	__________________________

Medication: (include non-prescription)

____

____

Have you ever taken Fen-Phen/Redux? NO YES

Patient Social History:

Marital Status	Single: ______	Married: ______	Separated: _______	Divorced: _______	Widowed: _______
Use of Alcohol	Never: ______	Rarely: _______	Moderate: _______	Daily: ________	
Use of Tobacco	Never: ______	Rarely: _______	Moderate: _______	Daily: _________________	
Use of Drugs	Never: ______	Type/Frequency: ____			
Excessive Exposure At home or at work to:	Fumes: ______	Dust: ______	Solvents: ______	Airborne Particles: _______	Noise: _______

CLINICIAN SIGNATURE: _________________________________DATE REVIEWED:________________________

ProHealth Physical Medicine

Name:__________________________ DOB __________________ Date:___________________

Family Medical History:

	Age	Disease	If Diseased, Cause Of Death
Father	_________	____________________	____________________
Mother	_________	____________________	____________________
Siblings	_________	____________________	____________________
	_________	____________________	____________________
	_________	____________________	____________________
Spouse:	_________	____________________	____________________
Children:	_________	____________________	____________________
	_________	____________________	____________________
	_________	____________________	____________________

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain Between	1 2 3 4 5
Shoulder Blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, Tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Constipation	1 2 3 4 5
Irritability	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling Foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To The Best of My Knowledge, The questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my Responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____________________________________ ____________________

Signature of the Patient, Parent or Guardian Date

Doctors Review

____________________________ ______________________

Signature of Doctor Date