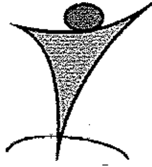

Professional Rehabilitation Associates, PSC
Electromyography Laboratory
116 Meridian Way Suite 9
Richmond, KY 40475
Phone:(859) 626-3131

Reset Form

New Patient Information

Last Name: ______________________ Date of Birth: ______________________

First Name: ______________________ Middle Initial: ____ Home Phone: ______________________

Street: ______________________ Social Security #: ______________________

City: ______________ State: ______ Zip: ________ Sex: ☐ Male ☐ Female

Employer: ______________________ Work Phone: ______________________

Street: ______________________ Occupation: ______________________

City: ______________ State: ______ Zip: ________ Supervisor: ______________________

Responsible Party/Card Holder Information

Last Name: ______________________ Relationship to Patient: ______________________

First Name: ______________________ Daytime Phone: ______________________

Street: ______________________ Work Phone: ______________________

City: ______________ State: ______ Zip: ________ Date of Birth: ____________ SSN: ____________

Emergency Contact Information

Full Name: ______________________ Daytime Phone: ______________________

Relationship to Patient: ______________________ Work Phone: ______________________

Is this injury related to: Automobile Accident: ☐ Worker's Compensation: ☐ Other: ______________________

____

Describe Injury: ____

Date of Injury/Onset: ____________ Did you report the injury? ☐ No ☐ Yes Date Reported: ____________

How did you hear about us? ☐ Physician Referral ☐ Newspaper ☐ Phone Book ☐ Family/Friend Other: ____________

Your referral to this facility may have been as a result of our ongoing marketing efforts to current or potential referral sources.

I hereby authorize payment of medical benefits to Professional Associates, PSC for services rendered. I further authorize the release of medical information required to process an insurance claim on my behalf. I certify a copy of the authorization to be a valid original. All costs of services not paid for by my insurance will become my responsibility.

Patient Signature: ______________________________ Date: ____________

Responsible Party Signature: ______________________________ Date: ____________

Evaluating Electromyographer: ______________________________ Print Form

Professional Rehabilitation Associates, PSC
Electromyography Laboratory
116 Meridian Way Ste 9
Richmond, KY 40475
(859) 623-3131 phone
(859) 625-1109 fax

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS AND REPORTS

I, the undersigned, hereby authorize ______________________________ to release the following information of the health record(s) of the below named patient:

____

Patient Name | Patient Address | Date of Birth | Phone

Information to be released:

( ) Entire Record	( ) Op Report	( ) Lab Report
( ) Discharge Summary	( ) Path Report	( ) Outpatient
( ) H&P	( ) X-ray Report	

( ) Other (specify): ____

Date(s) of Service: ____

Information to be released to:

____

Name of Person or Institution | Address

For the following purpose: ____

I understand that I have the right to revoke this authorization at any time except to the extent Richmond Physical Therapy has already acted as a result of this authorization. I further understand that any revocation must be provided in writing to PRA as identified in the Notice of Privacy Practices.

I also understand that when information is used or disclosed based on an authorization; the information may be re-disclosed by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information.

This authorization shall expire within ______ days from the date of this authorization.

I understand that I have the right to refuse to sign this authorization and that PRA will not condition treatment on the provisions of this authorization.

____

Signature of Patient or Legal Representative | Date

____

If signed by the Patients Legal Representative, please provide a description of Legal Representative's authority to act on behalf of the Patient.

PROFESSIONAL REHABILITATION ASSOCIATES, PSC
Electromyography Laboratory

Acknowledgment of Receipt of Notice of Privacy Practices

This is to acknowledge my receipt of PRA's Notice of Privacy Practices on the date stated below.

____
Date of Patient's or Personal Representative's Signature

____
Signature of Patient or Personal Representative

____
Patient's Name

____

____
Patient's Address

____
Name of Personal Representative
(If applicable)

____

____
Description of Representative's Authority to Act for the Patient (If Applicable)

Professional Rehabilitation Associates, PSC

Electromyography Laboratory Authorization & Consent For Testing

Electromyography (EMG) and Nerve Conduction Testing (NCS) are patient services provided in response to a wide variety of medical conditions for patients of all ages, regardless of gender, color, race, creed, national origin or disability.

The purpose of EMG/NCS testing is to evaluate the neuromuscular system and to find diseases that damage the nerves, muscles or the junctions between the nerves and muscles (neuromuscular junction).

All procedures will be thoroughly explained to you. During the NCS, mild electric currents will be applied to the skin on parts of your body. This is done to assess how quickly impulses travel in nerves and the NCS testing may be repeated on several different nerves. The EMG assesses muscle function. A fine needle electrode will be placed under your skin into the muscle being tested. The needle measures the electrical activity in your muscles and it may be repeated on several muscles. You also will be asked to contract your muscles during the EMG.

There are certain inherent risks with EMG/NCS. During EMG, you may experience some discomfort similar to an injection and may have some residual soreness and bruising for a few days. EMG may also cause false results on muscle enzyme laboratory tests and muscle biopsies. There may also be other risks depending on your medical condition; please discuss those with your referring physician or with your electromyographer. During NCS testing, you may feel a shock-like sensation as the nerve is stimulated even though the amount of voltage applied is very small. You may feel your muscles twitch. As with EMG testing, there may be other risks depending on you medical condition; please discuss those with your referring physician or with your electromyographer.

Based on the above information, I agree to cooperate fully and to participate in the procedure. I acknowledge that I have read this authorization and agree to be compliant. I acknowledge that I have had the procedures explained to me.

_______________________________ _______________
Patient Signature Date

_______________________________ _______________
Witness Signature Date

Professional Rehabilitation Associates, PSC

Electromyography Laboratory New Patient Information

Name: ______________________ Date: __________ Birthdate: __________ Age: ____

Referring physician: ______________________ Height: ______ Weight: ______

CURRENT CONDITION(S) / CHIEF COMPLAINT(S)

1. Describe the problem(s) / symptom(s) for which you are here:

____

____

2. When did the problem(s) / symptoms(s) begin (date/estimate if necessary)? __________

3. What happened? ____

____

4. If you are here following surgery, what was the date of your surgery? __________
   a. Have you ever had the problem(s) before?
      i. Yes ___
         1. What did you do for the problem(s)? ____________________
         2. Did the problem(s) get better? Yes___ No___
         3. About how long did the problem(s) last? ____________________
      ii. No ___

5. Are you receiving care for the problem(s) / symptoms(s) now? Ice, medications, etc...? Yes___ No___

   Describe: ____

6. What makes the problem(s) better? ____

7. What makes the problem(s) worse? ____

8. Are you seeing anyone else for the problem(s) / symptom(s)? (Check all that apply)

Chiropractor ___	Family physician ___	Orthopedist ___
Neurologist ___	Neurosurgeon ___	Pain management ___
Dentist ___	Rheumatologist ___	Other: __________

MEDICAL / SURGICAL HISTORY

1. Please circle if you have ever had:

Arthritis	Broken bones	Osteoporosis	Thyroid problems
Blood / bleeding disorders	Circulation problems	Heart problems	High blood pressure
Lung problems	Stroke/TIA	Cancer	Muscular dystrophy
Diabetes	Low blood sugar	Head injury	Hepatitis
Multiple sclerosis	Tuberculosis	Kidney problems	Repeated infections
Ulcers/stomach problems	Skin diseases	Depression	Blindness/glaucoma
Chronic fatigue	Deafness	Epilepsy/seizure	Back & or neck pain
Pacemaker	Other: ____________________		

2. Within the past year, have you had any of the following symptoms? (Circle all that apply)

Chest pain	Hoarseness	Cough	Heart palpitations
Shortness of breath	Dizziness/blackouts	Loss of balance	Coordination problems
Difficulty walking	Joint pain or swelling	Pain at night	Weakness in arms or legs
Difficulty sleeping	Loss of appetite	Nausea/vomiting	Difficulty swallowing
Bowel problems	Weight loss/gain	Urinary problems	Fever/sweats/chills
Headaches	Hearing problems	Vision problems	Muscle pain/tenderness
Tremors	Muscle wasting	Back or neck pain	Other: __________

3. Have you ever had surgery? Yes____ No ____ If yes, please describe and include dates or years:

____

4. **For men only:** Have you been diagnosed with prostate disease? Yes____ No ____

5. **For women only:** Are you or do you think you might be pregnant? Yes ____ No____

OTHER CLINICAL TESTS: Within the past year, have you had any of the following tests? (Circle all that apply)

MRI
CT scan
X-rays
NCV/EMG
Arthroscopy
Biopsy
Blood tests
Bone scan
Doppler ultrasound
Echocardiogram
EEG
EKG
Mammogram
Stress test
Myelogram
Other:__________

If positive, please describe:____

____

MEDICATIONS

1. Do you take prescription medications? Yes ____ No____

   If yes, please list: ____

   ____

2. Do you take any nonprescription medications? (Circle all that apply)

   Advil/Aleve
   Antacids
   Ibuprofen/Naproxen
   Antihistamines
   Aspirin
   Decongestants
   Herbal supplements
   Tylenol
   Other:______________________________

FUNCTIONAL STATUS / ACTIVITY LEVEL (Check all that apply)

____Difficulty with getting in and out of bed
____Difficulty walking on level ground
____Difficulty walking on uneven terrain
____Difficulty with self-care (bathing, dressing, etc..)
____Difficulty transferring (bed to chair, bed to commode, etc.)
____Difficulty climbing stairs
____Difficulty with work/school activities
____Difficulty with recreation or play activities
____Difficulty with home management (household chores, shopping, driving, caring for dependents)

SOCIAL HISTORY/LIVING ENVIRONMENT

With whom do you live?

____Alone
____Other relatives
____Spouse alone
____Child
____Spouse & others
Other: ______________________________
____Personal care attendant

Do you use:

____Cane ____Walker ____Manual wheelchair ____Motorized wheelchair

Employment/work (job/school/play)

____Working full-time outside of home
____Working full-time from home
____Homemaker
____Unemployed
____Working part-time outside home
____Working part-time from home
____Retired
____Student

Occupation: ____

GENERAL HEALTH STATUS

Please rate your health: ____Excellent ____Good ____Fair ____Poor

Do you smoke? ____Yes ____No Frequency/Amount________________________

Do you drink alcoholic beverages? ____Yes ____No Frequency/Amount______________________

Do you have any known allergies (latex, cortisone)? ______________________________________

Do you drink caffeinated beverages? ____Yes ____No Frequency/Amount______________________