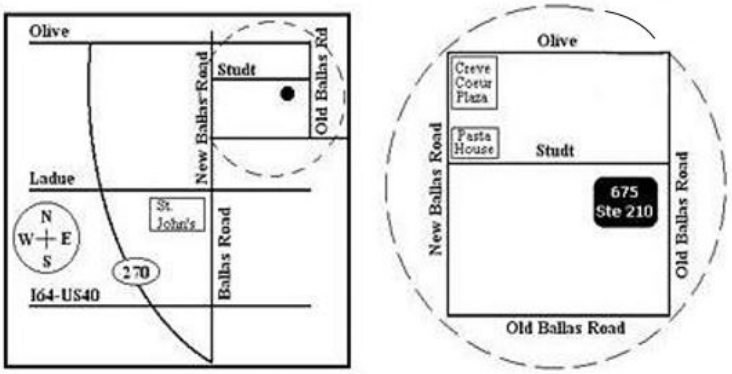
PERFORMANCE REHABILITATION & REGENERATION

IV NUTRIENTS • STEM CELLS/PRP • NERVE STUDIES

PERFORMANCE REHABILITATION
IS LOCATED AT
675 OLD BALLAS, SUITE 210
WE ARE AT THE CORNER OF OLD BALLAS ROAD AND STUDT ROAD



675 Old Ballas Road, Suite 210
St. Louis, MO 63141

PLEASE CHECK OUT OUR WEBSITE AT WWW.RAVIYADAVA.COM
FOR A MORE DETAILED MAP

Please fill out your form in its entirety prior to arriving for your appointment. All questions are designed to help Dr. Yadava serve you optimally. Please limit your answers to the choices given. Timely completion (traditionally no longer than 15 to 20 minutes) will allow for Dr. Yadava to spend the entirety of your appointment time with you. You will have an opportunity to expand on your answers when you are seen. Please do not leave any blanks. If there are questions that do not apply to you, please mark N/A. Thank you for helping us to serve you, as well as our other patients, in a timely manner.

IMPORTANT REMINDERS:

Please cancel or reschedule all appointments at least 24 hours in advance so that we may accommodate all patients in a timely fashion. No show appointments or cancellations **without** 24 hour notice will result in a $25 service fee.

Your copay and any applicable deductible or coinsurance is expected at the time of your visit. Please be aware that if you choose to pay for our services by credit/debit card, our credit card machine automatically adds a 4% service charge. However, if you choose to pay by cash, check or money order, there will not be a service fee added.

In order to serve our patients in a timely and comprehensive manner, we ask that you please bring in any **imaging study reports** and films (ie. x-rays, MRI, CT, etc.) that relate to your current medical issue

We appreciate your cooperation. Thank you for helping us to serve you and all of our patients in a timely and efficient fashion.

DR. RAVI YADAVA
675 Old Ballas Road, Suite 210~ St. Louis, MO 63141
Ph: 314-994-WELL Fax: 314-994-0796
www.raviyadava.com

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Dr. Ravi Yadava

Please complete form in its entirety

Name:_____ Date:_____ Date of Birth:_____ Age:____

Primary Doctor:_____ Referred by:_____

Height:_____ Weight:_____ Right handed:_____ Left handed:_____

CHIEF COMPLAINT: What are you being seen for today?_____

Date of Onset:_____ Is this problem due to a liability injury? ____ Yes ____ No

Have you had any problems before with this same area? ____ Yes ____ No

Were you hurt at work? ____ Yes ____ No

You are currently on: ____ Full Time ____ Modified/Off Work ____ Part Time ____ Retired

How long have you been on modified duty or off work?_____

What started your problem or pain?

_____
_____
_____
_____

TREATMENTS have included? ____ No medications, therapy, injections, braces or casts.

___ Physical therapy or exercise ___ Anti-inflammatory medication ___ Massage or Ultrasound
___ Traction ___ Pain Medications ___ Bracing/Cast
___ Manipulation/Chiropractic Care ___ Cortisone injections, where?_____
___ Other

Previous doctors seen about this problem: ____ None

Doctor	Specialty	Date	Treatments

TESTS done to evaluate your problem: ____ None

	Date	Location	Results
Plain X-rays			
MRI/CT			
EMG/NCV			
Bone Scan			
Arthrogram			

ALLERGIES: List any medications to which you are allergic or cannot take. Please list nature of reaction to medication.

____ None

_____
_____

MEDICATIONS you take: (Please print clearly-if you do not know the name, write what you take it for)
____ None

_____

_____

MEDICAL HISTORY: Please list any medical problems that you have:

_____

_____

_____

SURGICAL HISTORY: Please list any previous surgeries.
____ No surgeries

Operation Surgeon Date

_____

_____

FAMILY HISTORY: Please list any medical problems experienced by family members and which member experiences it:

_____

_____

_____

SOCIAL HISTORY:
Work Status: ____ Homemaker ____ Working ____Unemployed ____ Retired
____ Disabled ____Medical Absence ____Modified Duty-list restrictions_____

Occupation:_____

Marital Status: ____ Married ____ Single ____Widowed ____Divorced

Tobacco Use: ____Never ____Cigar ____Chew ____Pipe
____Cigarettes_____packs per day for_____years
____Quit When?_____after smoking_____packs per day for_____years.

Alcohol: ____Never ____Social ____Alcoholic ____Recovering alcoholic

Drug Abuse: ____Never ____Currently ____In the past

REVIEW OF SYSTEMS: Please check any condition that you have experienced.

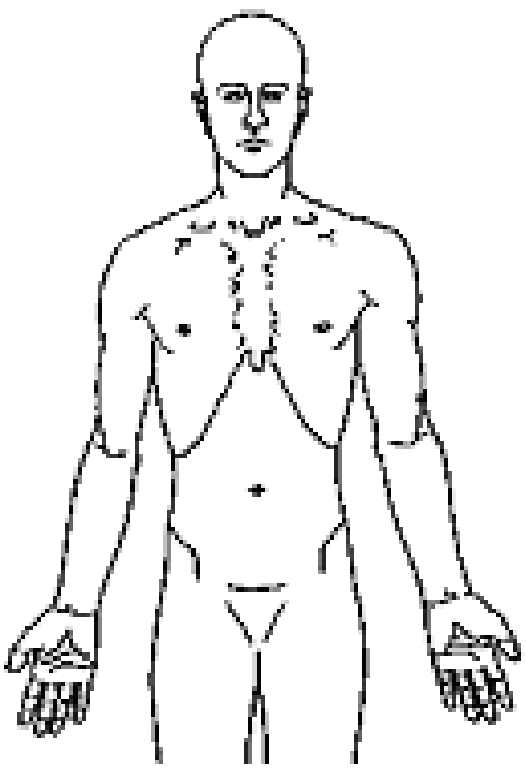
	Yes	No		Yes	No
Recent nausea or vomiting	___	___	Nosebleeds	___	___
Hot or Cold Spells	___	___	Stomach pain	___	___
Swollen ankles	___	___	Ulcers	___	___
Difficulty swallowing	___	___	Fever or chills	___	___
Morning cough	___	___	Constipation	___	___
Shortness of breath	___	___	Poor appetite	___	___
Heart or chest pain	___	___	Burning with urination	___	___
Abnormal heartbeat	___	___	Recent diarrhea	___	___
Calf cramps with walking	___	___	Frequent headaches	___	___
Loss of hearing	___	___	Blackouts	___	___
Seizures	___	___	Recent weight change	___	___
Nervous exhaustion	___	___	Metal implants	___	___
Claustrophobia	___	___	Pacemaker	___	___
Metal in eye	___	___			

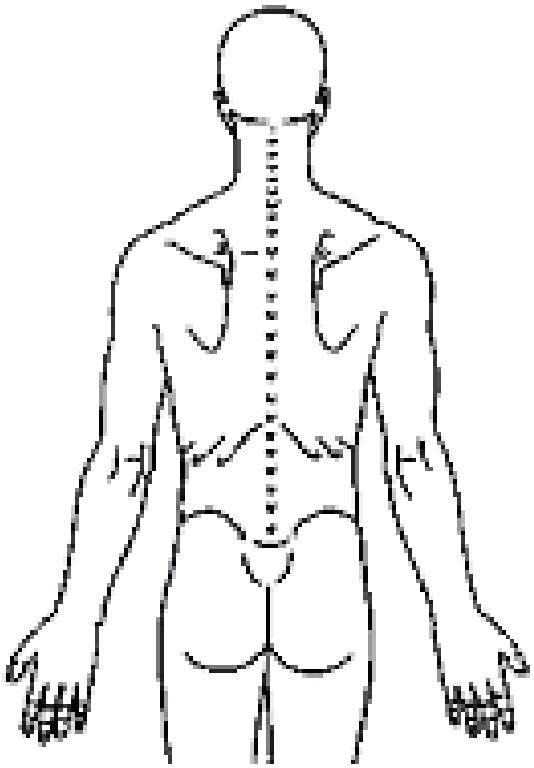
Have you discussed these problems with your primary doctor? ____ Yes ____ No

Reviewed and noted:_____ Date:_____

Indicate on the diagram where your pain is located and what type of pain you feel at the present time. Use the symbols to describe your pain. Please do not indicate areas of pain which are not related to your present injury or condition.

/// Stabbing xxx Burning ooo Pins & Needles === Numbness +++ Aching





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Patient Name :_____ DOB: _____ SSN: _____
(First Last MI)
Marital Status: S M W D Sex: M F Other _____

Address: _____
(Street) (City) (State) (Zip)
Phone: (Home)_____ (Work)_____ (Ext)_____

Optional: Cell Phone: _____ Email:_____ Fax:_____

Are you between 18 and 26 years of age and a full time student? YES NO
Have you treated with Dr. Yadava before? YES NO
Is condition related to: an auto accident ☐ a job injury ☐ liability accident ☐ no injury ☐

BODY PART: _____

DATE OF INJURY/SYMPTOMS ___/___/___
(specific date required by insurance companies)

Have you retained an attorney? YES NO
If YES, please provide information below:
Name: _____
Address: _____
_____
Phone: _____

Patient's Employer: _____ Spouse's Employer _____

Address_____ Address_____

Phone_____ Phone_____

Pharmacy Name/Zip Code/Ph #:_____

Must Be Completed

Primary Insurance Coverage	**Secondary Insurance Coverage**
Ins. Co._____	Ins. Co._____
ID # _____	ID # _____
Group # _____	Group # _____
Cardholder's Name_____	Cardholder's Name_____
Cardholder's DOB_____	Cardholder's DOB_____
Cardholder's SS# _____	Cardholder's SS#_____

EMERGENCY CONTACT (Relative/Friend not residing with you)

Name:_____ Phone:_____ Relationship:_____
Referred By:_____ Phone:_____

Did you bring any Medical Records or X-rays that you would like for Dr. Yadava to consider? Yes ☐ No ☐
(If yes, please present these to the receptionist immediately.)
I have reviewed the above information and it is accurate and current. **Please Initial and Date** _____
If you are under the age of 18, please have parent or guardian initial above and sign the consent form.

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CONSENT

I hereby authorize my Doctor (or whomever he may designate) to administer such medical treatment as is necessary for a patient in my condition.

I understand that any x-rays taken in this office are read and interpreted as a part of my care by Dr. Yadava. I understand that Dr. Yadava is not a radiologist and that if I wish to have my x-rays read by a radiologist that this will be accommodated upon request at my own expense.

I hereby authorize Performance Rehabilitation to furnish my Insurance Carrier(s), Attorney, Legal Representative and Referring and/or Consulting Health Care Providers all information concerning my present illness or injury.

I understand that I am financially responsible for any charges not covered by my insurance, and any charges incurred as a result of collection (i.e. Attorney fees, court costs and Collection Agency fees). ALL insurances/HRA/HSAs after my primary are MY responsibility to file and balances after said primary insurance are MY responsibility regardless if my secondary or HSA/HRA pay my claim(s) or not.

By signing below, I understand that all cell phones, tablets, etc. are required to be silenced at the time of service. I also understand that it is prohibited for any recording, including video or audio, to be taken while in the office.

Appointment confirmation: I wish to be contacted for confirmation of my appointments with Dr. Yadava by text message: _____. By providing our office with this information, you authorize consent to be contacted by the above stated method. Performance Rehabilitation is not directly charging you to receive these messages; however, standard message and data rates may apply.

Email update consent: I wish to sign up for emails regarding patient care updates, surveys, promotions, services, etc. at _____. I understand that I can opt out of these emails at any given time.

Cancellation policy: Please cancel or reschedule all appointments at least 24 hours in advance so that we may accommodate all patients in a timely fashion. No show appointments or cancellations without 24 hour notice will result in a $25 service fee.

Please be aware that if you choose to pay for our services by credit/debit card, our credit card machine automatically adds a 4% service charge. However, if you choose to pay by cash, check or money order, there will not be a service fee added.

There is a $35.00 service fee for all CHECKS RETURNED BY YOUR BANK for any reason; this is what our bank charges us.

A $5 per month service fee will be added to your account for all balances over 30 days old.

Assignment of Benefits: I hereby authorize payment of medical and surgical benefits, provided by the insurance carrier, to Performance Rehabilitation.

SIGNATURE **DATE**