RAPID5 Multidimensional Health Assessment Questionnaire (MDHAQ) **Provider:**_____ MA:_____

Name:_____ **Date of Birth**:_____ **Date**: _____

What hurts you most today? _____ **Circle where you live:** Private Residence Assisted Living Nursing Home

1. Over the past week, were you able to:	**No** Difficulty (0)	**Some** Difficulty (1)	**Much** Difficulty (2)	**Unable** to do (3)
Dress yourself, tie shoes, do buttons?				
Get in and out of bed?				
Lift a full cup or glass to your mouth?				
Walk outdoors on flat ground?				
Wash and dry your entire body?				
Bend down to pick up clothing from the floor?				
Turn regular faucets on and off?				
Get in and out of a car, bus, train, or airplane?				
Walk two miles?				
Participate in sports?				

2. Over the PAST WEEK how severe has your pain been? Circle one

No Pain 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

3. Check the appropriate spot to indicate the amount of pain you are having today.

LEFT	No Pain	Mild	Moderate	Severe	**RIGHT**	No Pain	Mild	Moderate	Severe
Fingers	[ ]	[ ]	[ ]	[ ]	**Fingers**	[ ]	[ ]	[ ]	[ ]
Wrist	[ ]	[ ]	[ ]	[ ]	**Wrist**	[ ]	[ ]	[ ]	[ ]
Elbow	[ ]	[ ]	[ ]	[ ]	**Elbow**	[ ]	[ ]	[ ]	[ ]
Shoulder	[ ]	[ ]	[ ]	[ ]	**Shoulder**	[ ]	[ ]	[ ]	[ ]
Hip	[ ]	[ ]	[ ]	[ ]	**Hip**	[ ]	[ ]	[ ]	[ ]
Knee	[ ]	[ ]	[ ]	[ ]	**Knee**	[ ]	[ ]	[ ]	[ ]
Ankle	[ ]	[ ]	[ ]	[ ]	**Ankle**	[ ]	[ ]	[ ]	[ ]
Toes	[ ]	[ ]	[ ]	[ ]	**Toes**	[ ]	[ ]	[ ]	[ ]
Neck	[ ]	[ ]	[ ]	[ ]	**Back**	[ ]	[ ]	[ ]	[ ]

4. Considering all the ways illness and health conditions affect you, circle how you are doing today.

WELL 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 POORLY

5. Do you feel stiff in the morning? Yes No **How long are you stiff for?** _____ mins _____ hours

6. Circle your smoking status: Former Smoker Current everyday Current some days Never smoked

7. Allergies: _____

8. Email Address: _____ **@** _____

DO NOT WRITE BELOW THIS- FOR MD USE ONLY-MD Global

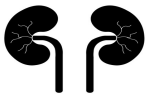
Very Well 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 Very Poorly
☐ ☐

FN 0-10	
1=0.3 16=5.3 2=0.7 17=5.7 3=10 18=6.0 4=1.3 19=6.3 5=1.7 20=6.7 6=2.0 21=7.0 7=2.3 22=7.3 8=2.7 23=7.7 9=3.0 24=8.0 10=3.3 25=8.3 11=3.7 26=8.7 12=40 27=9.0 13=4.3 28=9.3 14=4.7 29=9.7 15=5.0 30=10	
PN 0-10	
PTGL 0-10	
RAPID3 0-30	
JT CT 0-10	
1=0.2 25=5.2 2=0.4 26=5.4 3=0.6 27=5.6 4=0.8 28=5.8 5=1.0 29=6.0 6=1.3 30=6.3 7=1.5 31=6.4 8=1.7 32=6.7 9=1.9 33=6.9 10=2.1 34=7.1 11=2.3 35=7.3 12=2.5 36=7.5 13=2.7 37=7.7 14=2.9 38=7.9 15=3.1 39=8.1 16=3.3 40=8.3 17=3.5 41=8.5 18=3.8 42=8.8 19=4.0 43=9.0 20=4.2 44=9.2 21=4.4 45=9.4 22=4.6 46=9.6 23=4.8 47=9.8 24=5.0 48=10	
RAPID4 0-40	
MDGL: 0-10	
RAPID5 0-50	

Name:_____ **Date of Birth**: _____ **Date**: _____

Check if you experienced any of the following in the last month:

Eyes	Constitutional	Ear, Nose, Throat	Cardiovascular	Respiratory	Gastrointestinal
					
☐ Pain ☐ Redness ☐ Vision loss ☐ Double/blurred vision ☐ Dryness ☐ Itching	☐ Weight gain ☐ Weight loss ☐ Fatigue ☐ Weakness ☐ Fever	☐ Ringing in ears ☐ Loss of hearing ☐ Nosebleeds ☐ Loss of smell ☐ Dryness in nose ☐ Runny nose ☐ Bleeding gums ☐ Oral sore ☐ Loss of taste ☐ Dryness of mouth ☐ Frequent sore throats ☐ Hoarseness ☐ Difficulty in swallowing	☐ Pain in chest ☐ Irregular heartbeat ☐ Sudden changes in heartbeat ☐ High blood pressure	☐ Shortness of breath ☐ Difficulty breathing ☐ Swollen legs or feet ☐ Cough ☐ Coughing of blood ☐ Wheezing	☐ Nausea ☐ Vomiting ☐ Stomach pain ☐ Diarrhea ☐ Constipation ☐ Jaundice ☐ Blood in stools ☐ Black stools ☐ Heartburn

Genitourinary	Musculoskeletal	Integumentary	Neurologic	Psychiatric	
					
☐ Difficult urination ☐ Pain or burning on urination ☐ Blood in urine ☐ Cloudy urine	☐ Joint pain ☐ Morning stiffness ☐ Muscle weakness ☐ Muscle tenderness ☐ Joint swelling	☐ Easy bruising ☐ Redness ☐ Rash ☐ Hives ☐ Sun sensitivity ☐ Tightness ☐ nodules/bumps ☐ Hair loss ☐ Color changes of hands/feet	☐ Headaches ☐ Dizziness ☐ Fainting ☐ Muscle spasms ☐ Memory loss ☐ Tingling ☐ Night sweats	☐ Excessive worries ☐ Anxiety ☐ Easily losing temper ☐ Depression ☐ Agitation ☐ Difficulty falling asleep ☐ Difficulty staying asleep	

Name:_____ **Date of Birth**: _____ **Date**: _____

History

Who referred you? _____ Name of Primary Medical Doctor: _____

Briefly describe your symptoms: _____

_____

Previous treatment for symptoms: _____

_____

Previous doctors that treated your symptoms: _____

Date of last: Eye Exam _____ Chest X-Ray _____ TB Test _____ Hepatitis Test _____

Medical History

Check all that apply

☐ Acid reflux/GERD	☐ Kidney Disease
☐ Anemia	☐ Lupus
☐ Ankylosing Spondylitis	☐ Lung cancer/Lung disease
☐ Anxiety	☐ MS
☐ Arrhythmia	☐ Migraine
☐ Asthma	☐ Obesity
☐ Bell's palsy	☐ Osteoarthritis
☐ COPD	☐ Osteoporosis
☐ Cancer: _____	☐ Parkinson's
☐ Crohns	☐ Psoriasis
☐ Diabetes Type 1 or Type 2	☐ Raynaud's
☐ Depression	☐ Rheumatoid Arthritis
☐ Eating disorder	☐ Scoliosis
☐ GI disease	☐ Seizures/Epilepsy
☐ Gout	☐ Skin Problems
☐ Hearing problems	☐ STD's
☐ Hepatitis A B C	☐ Stomach Ulcers
☐ HIV	☐ Stroke
☐ Hodgkin's	☐ Tuberculosis
☐ Hypertension	☐ Thyroid Disease
☐ Insomnia	☐ Vision Problems
☐ Joint Injuries	☐ Other: _____

Trauma History	Date/Brief Description
☐ Car accident	
☐ Work related	
☐ Fracture	
☐ Fall	

Name:_____ **Date of Birth**: _____ **Date**: _____

Surgery/Procedure History	Date

Social History

Daily alcohol intake: _____ cups per day

Recreational drug use? Yes No Is yes, please list: _____

Exercise regularly? Yes No Is yes, please list: _____

Sleep _____ hours per night

Family History Diagnosis	Relationship

Current Medications	Dose/Frequency

Name:_____ **Date of Birth**: _____ **Date**: _____

HIPAA Patient Consent of Information

Allegra Arthritis Associates P.C., in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physician and staff from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail, or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Allegra Arthritis Associates P.C. physicians and its staff leave a message on an answering machine, voicemail, or with a specified individual. You may specify what information is left and with whom by noting the information on this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I _____ give my consent to Allegra Arthritis Associates P.C. physicians and staff to leave a message regarding scheduling, treatment, surgery, lab results, or radiology results, or other information as necessary.

_____ _____
Patient Name Date of Birth

_____ _____
Signature Date

Name of HIPAA approved contact: _____
This is the individual you consent to speak to our providers or office staff regarding your medical information.

Relationship: _____

[ ] Please check here if you do NOT consent to messages being left on voicemail or on your answering machine.

[ ] Please check here if you do not wish for our providers or office staff to discuss your medical information with anyone apart from yourself (the patient).

Name:_____ **Date of Birth**: _____ **Date**: _____

Patient Financial Policy

Your clear understanding of our patient financial policy is important to our professional relationship. It is the responsibility of the patient to notify our front office staff of any changes in patient information including insurance, name, address, etc.

All payments to our office must be made by cash or check. No credit card payments are accepted.
All checks must be written out to Allegra Arthritis Associates P.C.

All copayments are due at the time you check in at the front desk **prior** to being seen by a provider. **No exceptions.** An ATM is available inside the Keyport lobby and across the street from the Red Bank and Hazlet offices. Please come prepared to avoid any inconveniences.

Insurance It is the patient's responsibility to provide the office with the current insurance information. We will ask for your insurance card at your first visit to obtain in our records. We may occasionally request a copy at a later date to update your records so please have your insurance card every time you come to the office. If current information is not obtained at the time of service, it will become the patient's responsibility to pay until current information is provided to the office.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account.**

Unpaid Balances We ask that full payment be made at the time of service unless prior arrangement has been made through the billing office. All outstanding balances must be paid PRIOR to being seen by a provider. If your insurance company has not paid the balance in full you will receive a statement notifying you of the amount due unless the balance is less than $8.00. If you have not received a statement one will be provided to you in the office.
Payment Arrangements In the event the total balance due is more than you are able to pay; we will make reasonable payment arrangements. Please contact our billing manager to make such arrangements.
Returned Checks The charge for a returned check is $30.00 payable by cash only. This will be applied to your account and is inclusive of the insufficient funds amount. You will be placed on a "cash only" basis following any returned check.
Uninsured Patients The fee for a new patient without insurance is $250, with an injection $350. New patient payments are to be in cash only. The fee for an established patient without insurance is $100, with an injection $200. This payment can be made by cash or check. .All payments for service are due prior to seeing the doctor.
Document Fees The final cost of these services shall be approved by the billing manager and may change dependent upon the amount of work involved.

- Medical Records $1.00 per page up to $100, requested through the patient portal.
- Letter written and signed by the provider $50
- Paperwork to be filled out by provider (disability, FMLA, psychician statements) $50 for first page and $15 for additional pages.

By signing below I acknowledge that I have read and received a copy of Allegra Arthritis Associates P.C. Financial Policy.

_____	_____	_____
Patient Name	Signature	Date