

Patient History & Intake Form

Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____ SSN: _____
Today's Date: _____ Injury/Symptoms Date: _____ Height: _____ Weight: _____
Address: _____ City _____ State _____ Zip Code _____
Home Phone: _____ Cell Phone: _____ Email: _____
Pharmacy: _____ Primary Care Provider: _____ Referring Provider: _____
Right or Left Handed _____ Preferred Language: _____ Race: _____ Ethnicity: _____
Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced Sex: ☐Male ☐Female
Are You Currently Employed: ☐Yes ☐No ☐Retired ☐Disabled ☐Student
Employer's Name: _____ Job Description: _____
Employer's Address: _____ City _____ State _____ Zip Code _____

Spouse/Parent Information

Name: _____ Relationship: _____
Address: _____ City _____ State _____ Zip Code _____
Home Phone: _____ Cell Phone: _____ Date of Birth: _____ SSN: _____
Employer: _____ Employer's Address: _____
(Street) (City) (State) (Zip code)

Name: _____ Relationship: _____
Address: _____ City _____ State _____ Zip Code _____
Home Phone: _____ Cell Phone: _____ Date of Birth: _____ SSN: _____
Employer: _____ Employer's Address: _____
(Street) (City) (State) (Zip code)

Financial Information

Person Responsible for Payment: _____ Relationship: _____
Phone Number: _____ Address: _____
(Street) (City) (State) (Zip code)

Emergency Information (Person to contact in case of an emergency, not currently living with you)

Name: _____ Relationship: _____
Address: _____ City _____ State _____ Zip Code _____
Home Phone: _____ Cell Phone: _____

I acknowledge a Notice of Privacy Practices has been made available to me, which provides a more complete description of information uses and disclosures; I understand that I am financially responsible for any charges not covered by my insurance company. I understand any unpaid balance assigned to a third party collection agency for collection, or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, will have a collection fee added. I agree to pay that fee and any other reasonable attorney fees and court costs. I understand and agree to the above terms.

Patient/Parent or Guardian Signature

Date

Family History (please inform us of your family members' medical history by marking the appropriate box):

☐ **No Family History** (checking this box indicates no past family medical history)

	Mother	Father	Sister	Brother	Daughter	Son	Other:
<i>Hypertension</i>							
<i>Osteoarthritis</i>							
<i>Osteoporosis</i>							
<i>Scoliosis</i>							
<i>Diabetes, Type 2</i>							
<i>Other</i>							

Social History (please check all that apply):

Cigarette Smoking

- ☐ Never Smoked
☐ Quit: former smoker
☐ Smokes less than daily
☐ Smokes daily
 ○ # packs per day _____

Alcohol Use

- ☐ Do not drink alcohol
☐ Less than 1 drink a day
☐ 1-2 drinks a day
☐ 3 or more drinks a day

Exercise Frequency

- ☐ Several times a day
☐ Once a day
☐ Few times a week
☐ Few times a month
☐ Never
☐ Other _____

Medications (please list all current medications or check option which applies):

- ☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option which applies):

- ☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Past Medical History (please check all that apply):

- | | | |
|--|--|---|
| ☐ Anemia, Chronic | ☐ Diabetes, Insulin Dependent | ☐ Multiple Myeloma |
| ☐ Anxiety | ☐ Diabetes, Non Insulin | ☐ Obesity, Morbid |
| ☐ Asthma | ☐ End Stage Renal Disease | ☐ Obesity |
| ☐ Irregular Heartbeat | ☐ GERD | ☐ PBPH |
| ☐ Bipolar Disorder | ☐ Hepatitis | ☐ Prostate Cancer |
| ☐ Breast Cancer | ☐ HIV/AIDS | ☐ Pulmonary Embolism |
| ☐ Hyperlipidemia | ☐ High Cholesterol | ☐ Radiation Therapy |
| ☐ Ischemic Heart Disease | ☐ Hyperparathyroidism | ☐ Fibromyalgia |
| ☐ Chronic Pain | ☐ Hypertension | ☐ Rheumatoid Arthritis |
| ☐ Colon Cancer | ☐ Hyperthyroidism | ☐ Sleep Apnea |
| ☐ COPD | ☐ Hypothyroidism | ☐ Seizures |
| ☐ Coronary Artery Disease | ☐ Leukemia | ☐ Stroke |
| ☐ Deep Vein Thrombosis | ☐ Lung Cancer | ☐ None |
| ☐ Depression | ☐ Lymphoma | ☐ Other: _____ |

Past Surgical History (please check all that apply):

- | | | |
|--|--|---|
| ☐ Appendix (Appendectomy) | ☐ Heart: Mechanical Valve Replacement | ☐ Rectum: Low Anterior Resection |
| ☐ Breast: Mastectomy
☐ Right ☐ Left ☐ Both | ☐ Heart: PTCA | ☐ Skin: Basal Cell Carcinoma |
| ☐ Breast: Lumpectomy
☐ Right ☐ Left ☐ Both | ☐ Kidney Stone Removal | ☐ Skin: Melanoma |
| ☐ Colectomy: Colon Cancer Resection | ☐ Kidney Transplant | ☐ Skin: Skin Biopsy |
| ☐ Colectomy: Diverticulitis | ☐ Liver: Hepatectomy | ☐ Skin: Squamous Cell Carcinoma |
| ☐ Colectomy: IBD | ☐ Liver: Liver Transplant | ☐ Hysterectomy |
| ☐ Colon: Colostomy | ☐ Liver: Shunt | ☐ Hysterectomy: Caesarean |
| ☐ Gallbladder Removal | ☐ Ovaries Removed: Ovarian Cancer | ☐ Hysterectomy: Uterine Cancer |
| ☐ Heart: Biological Valve Replacement | ☐ Ovaries: Tubal Ligation | ☐ Hysterectomy: Cervical Cancer |
| ☐ Heart: Coronary Artery Bypass Surgery | ☐ Pancreas: Pancreatectomy | ☐ None |
| ☐ Heart Transplant | ☐ Prostate Removed: Prostate Cancer | ☐ Other: _____ |
| | ☐ Prostate Removed: TURP | |
| | ☐ Rectum: APR | |

Past Orthopedic History (please check all that apply):

- | | | |
|---|---|--|
| ☐ Ankle Fracture | ☐ Osteoarthritis | ☐ Soft Tissue Sarcoma |
| ☐ Ankylosing Spondylitis | ☐ Osteopenia | ☐ Spinal Stenosis, Cervical |
| ☐ Bursitis | ☐ Osteoporosis | ☐ Spinal Stenosis, Lumbar |
| ☐ DISH | ☐ Primary Bone Sarcoma | ☐ Vertebral Body Compression Fracture |
| ☐ Epidural Injections, Spine | ☐ Psoriatic Arthritis | ☐ Vitamin D Deficiency |
| ☐ Fracture | ☐ Rheumatoid Arthritis | ☐ Wrist Fracture |
| ☐ Gout | ☐ Ricketts | ☐ None |
| ☐ Hip Fracture | ☐ RSD | ☐ Other: _____ |
| ☐ HNP, Cervical | ☐ Sciatica | |
| ☐ HNP, Lumbar | ☐ Scoliosis | |
| ☐ Metastatic Bone Disease | ☐ Spine Fracture | |

Past Orthopedic Surgery (please check all that apply):

- | | | |
|---|--|--|
| ☐ Achilles Tendon Repair
○Right ○Left ○Both | ☐ Joint Replacement: Hip
○Right ○Left ○Both | ☐ Reverse Total Shoulder Replacement
○Right ○Left ○Both |
| ☐ ACL Reconstruction
○Right ○Left ○Both | ☐ Joint Replacement: Knee
○Right ○Left ○Both | ☐ Revision of Total Knee Arthroplasty
○Right ○Left ○Both |
| ☐ Ankle Fracture ORIF
○Right ○Left ○Both | ☐ Joint Replacement: Shoulder
○Right ○Left ○Both | ☐ Revision of Total Shoulder Arthroplasty
○Right ○Left ○Both |
| ☐ Bunion Correction
○Right ○Left ○Both | ☐ Knee Arthroscopy
○Right ○Left ○Both | ☐ Rotator Cuff Repair
○Right ○Left ○Both |
| ☐ Carpal Tunnel Decompression
○Right ○Left ○Both | ☐ Kyphoplasty/Vertebroplasty | ☐ Shoulder Arthroscopy
○Right ○Left ○Both |
| ☐ Cervical Spine Surgery: ACDF | ☐ Lumbar Fusion | ☐ Trigger Finger Release
Location: _____ |
| ☐ Cervical Spine Surgery: Disc Replacement | ☐ Lumbar Laminectomy | ☐ Other: _____ |
| ☐ Distal Radius ORIF
○Right ○Left ○Both | ☐ Lumbar Spine Surgery: Decompression | |
| ☐ Ganglion Cyst Excision | ☐ Lumbar Spine Surgery: Decompression & Fusion | |
| ☐ Intermedullary Nailing Femur
○Right ○Left ○Both | ☐ Lumbar Spine Surgery: Disc Replacement | |
| ☐ Intermedullary Nailing Tibia | ☐ Meniscus Repair | |

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No
Joint pains		
Joint swelling		
Joint stiffness		
Unsteady gait		
Numbness		
Tingling		
Unexpected weight loss		
Fever		
Chills		
Poor healing wounds		
Scarring/Keloids		
Easy bleeding		

Alerts* (check yes or no for the following):

Alert	Yes	No
Pacemaker		
Blood thinners		
Defibrillator		
Premedication prior to procedures		
Rheumatoid Arthritis		
RSD		
Allergy to shellfish/iodine		
Allergy to latex		
Allergy to adhesive		
Under pain management/contract		

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.