New 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: ____________ SSN: _______________

Address: ___________________________City_________________State__________Zip Code___________

Home Phone: ____________ Cell Phone: ______________ Date of Birth: ___________

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 understand and have been provided a Notice of Privacy Practices that 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.

____

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:
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes, Type 2							
Other							

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

Past Surgical History (please check all that apply):

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

Past Orthopedic History (please check all that apply):

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

Past Orthopedic Surgery (please check all that apply):

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

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.