

**Is this a Work Related Injury? Yes / No**

**Is this a Motor Vehicle Injury? Yes / No**

**IF YOU ANSWERED YES TO EITHER QUESTION PLEASE  
SEE THE FRONT DESK FOR NEW PAPERWORK.**

DATE \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

Patient (Mr. Mrs. Miss) \_\_\_\_\_ Home Phone \_\_\_\_\_

Street Address \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Zip \_\_\_\_\_ Sex: M / F Age \_\_\_\_\_ Martial Status \_\_\_\_\_ SS# \_\_\_\_\_

Patient Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Student (Full or Part) \_\_\_\_\_ Where \_\_\_\_\_ Expected Graduation Date \_\_\_\_\_

Who is your primary physician? Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Did you go to the Emergency Room? Yes / No If yes, date \_\_\_\_\_ Hospital name? \_\_\_\_\_

Name of person to be notified in case of an emergency? \_\_\_\_\_ Phone # \_\_\_\_\_

**INSURANCE INFORMATION**

**IF YOU DO NOT PROVIDE ALL PROPER INSURANCE INFORMATION YOU WILL BE RESPONSIBLE FOR THE CHARGES.**

**Primary Private Insurance/No-fault (If work related fill out comp information on the separate workers comp form.)**

Name of Insurance Company \_\_\_\_\_ Identification/claim # \_\_\_\_\_

Address to send claim \_\_\_\_\_ Group/policy # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number \_\_\_\_\_ Co pay \$ \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

**Secondary Insurance**

Name of Company \_\_\_\_\_ Identification # \_\_\_\_\_

Address to send claim \_\_\_\_\_ Group # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number \_\_\_\_\_ Co pay \$ \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

**MEDICAL HISTORY**

Have you ever had any of the following? (Circle all that apply and fill in the blanks)

**ALLERGIES:** Environmental & Drug \_\_\_\_\_ Reaction \_\_\_\_\_

**BLOOD DISEASE:** AIDS/HIV Easy Bruising Hemophilia

**CANCER:** Specify \_\_\_\_\_ Cancer Surgery (type) \_\_\_\_\_ Chemo (when) \_\_\_\_\_ Radiation

**DIET:** Diabetic Recent Weight Loss Special Diet \_\_\_\_\_

**GASTRO-INTESTINAL:** Constipation Diabetes Diarrhea Hepatitis Hiatal Hernia Jaundice  
Liver Disease Nausea Ulcer

**HABITS:** Alcohol Abuse or Drug Abuse (past or present) Smoking (past or present)

**HEART:** Angina Artificial Heart Valves Cardiac Arrest Heart Arrhythmia Heart Attack (when) \_\_\_\_\_ Pacemaker

**INFECTION:** Dental Chronic \_\_\_\_\_ Recent \_\_\_\_\_ Lyme \_\_\_\_\_ Venereal Disease

**LUNGS:** Asthma Emphysema Shortness of Breath

**MUSCULOSKELETAL:** Artificial Joint Cervical Strain Herniated Disc Gout Lumbosacral Strain  
Old fracture Osteoarthritis Rheumatoid Arthritis Psoriatic Arthritis

**NERVOUS:** Epilepsy Headaches Nervous Condition Psychiatric Care Seizure Stroke

**VASCULAR DISEASE:** Arteriosclerosis High Blood Pressure Low Blood Pressure

**OTHER:** \_\_\_\_\_

Has your family had any of the above? \_\_\_\_\_

**DESCRIBE YOUR ORTHOPEDIC COMPLAINT & AFFECTED SIDE (RIGHT, LEFT OR BOTH):** \_\_\_\_\_

\_\_\_\_\_

**DATE PROBLEM STARTED** \_\_\_\_\_ **HOW DID PROBLEM START** \_\_\_\_\_

\_\_\_\_\_

Have you tried Physical Therapy? **Yes / No**

Have you taken Medications previously for this complaint? **Yes / No** \_\_\_\_\_

Are you under the care of a physician? **Yes / No** For what conditions? \_\_\_\_\_

Are you taking any medication at this time? **Yes / No** If yes, what? \_\_\_\_\_

Estimated Height and weight: \_\_\_\_\_ Are you right or left handed? **Rt Lt or Both**

Are you pregnant? **Yes / No** Are you nursing? **Yes / No** Are you on birth control? **Yes / No**

Is there anything else we should know about your medical history and previous surgeries? \_\_\_\_\_

\_\_\_\_\_