ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

ORTHORITY 360™ TOTAL BODY WELLNESS

# PATIENT INFORMATION
## INITIAL VISIT

| TODAY'S DATE |
|---|
| |

| FIRST NAME | MIDDLE NAME | LAST NAME |
|---|---|---|
| STREET ADDRESS I APT # | | PHONE NUMBER |
| CITY, STATE, ZIP | | CELL PHONE NUMBER |
| BIRTH DATE / GENDER ◯ M ◯ F ◯ OTHER | SOCIAL SECURITY NUMBER | EMAIL ADDRESS |
| RELIGIOUS PREFERENCE | IS A BLOOD TRANSFUSION ACCEPTABLE IN AN EMERGENCY? ◯ YES ◯ NO | |

MARITAL STATUS
◯ SINGLE ◯ MARRIED ◯ SEPARATED ◯ DIVORCED ◯ WIDOWED ◯ UNKNOWN

EMPLOYMENT STATUS
◯ FULL-TIME ◯ PART-TIME ◯ HOMEMAKER ◯ UNEMPLOYED
◯ FULL-TIME STUDENT ◯ PART-TIME STUDENT ◯ RETIRED ◯ DISABLED

ETHNIC IDENTITY
◯ CAUCASIAN ◯ AFRICAN AMERICAN
◯ HISPANIC/LATINO ◯ ASIAN
◯ NATIVE AMERICAN ◯ MIDDLE EASTERN
◯ PACIFIC ISLANDER ◯ OTHER

| EMPLOYER | WORK PHONE NUMBER |
|---|---|
| EMPLOYER ADDRESS, CITY, STATE, ZIP | |
| SPOUSE'S NAME / SPOUSE'S EMPLOYER | EMPLOYER PHONE NUMBER |

## RESPONSIBLE PARTY/ GUARANTOR

PLEASE COMPLETE WITH INSURED PARENT INFORMATION FOR MINORS/SPOUSE.

| NAME ◯ SELF | RELATIONSHIP TO PATIENT ◯ SELF | BIRTH DATE |
|---|---|---|
| STREET ADDRESS I APT # | | SOCIAL SECURITY NUMBER |
| CITY, STATE, ZIP | | PHONE NUMBER |
| EMPLOYER | | EMPLOYER PHONE NUMBER |
| EMPLOYER ADDRESS, CITY, STATE, ZIP | | |

IF UNDER THE AGE OF 18 PARENT'S/GUARDIAN'S NAME IS REQUESTED.*

| MOTHER'S NAME | MOBILE NUMBER |
|---|---|
| FATHER'S NAME | MOBILE NUMBER |
| GUARDIAN'S NAME | MOBILE NUMBER |

*MINOR CONSENT FORM MUST BE COMPLETED.

## CURRENT CONDITION

CHECK WHICH APPLY TO YOUR CURRENT CONDITION

◯ WORK-RELATED INJURY ◯ MOTOR VEHICLE ACCIDENT ◯ RECURRENCE OF PREVIOUS INJURY ◯ CAUSE UNKOWN
◯ INJURY RELATED TO LIFTING ◯ ATHLETIC/RECREATIONAL INJURY ◯ INJURY RELATED TO FALLING ◯ OTHER _____

| HAVE YOU HAD A RELATED SURGERY? | HAVE YOU HAD ANY TEST RESULTS? |
|---|---|
| ◯ YES ◯ NO | ◯ X-RAY ◯ MRI ◯ OTHER _____ |

## PRIMARY INSURANCE

| NAME OF INSURANCE | CERTIFICATE/POLICY/ID | GROUP NUMBER | |
|---|---|---|---|
| SUBSCRIBER NAME | RELATIONSHIP TO PATIENT ◯ SELF | BIRTH DATE | SOCIAL SECURITY NUMBER |

## SECONDARY INSURANCE

**WORKER'S COMPENSATION/AUTO ACCIDENT PATIENTS, PLEASE LIST PERSONAL INSURANCE AS SECONDARY HERE.**

| NAME OF INSURANCE | CERTIFICATE/POLICY/ID | GROUP NUMBER | |
|---|---|---|---|
| SUBSCRIBER NAME | RELATIONSHIP TO PATIENT ◯ SELF | BIRTH DATE | SOCIAL SECURITY NUMBER |

## WORKER'S COMPENSATION/AUTO ACCIDENT

PATIENT IS RESPONSIBLE REGARDLESS OF INSURANCE BENEFITS OR SETTLEMENT.

| WC/AUTO/CLAIM # | DATE OF INJURY/ ACCIDENT | HAVE YOU BEEN TREATED FOR THIS INJURY? ◯ YES ◯ NO |
|---|---|---|
| COMPANY/EMPLOYER AT TIME OF ACCIDENT | | NOTIFIED YOUR EMPLOYER OF ACCIDENT? ◯ YES ◯ NO |
| INSURANCE COMPANY NAME | | PHONE NUMBER |
| ATTORNEY NAME | | PHONE NUMBER |

## SCHOOL/ LEAGUE/REC INSURANCE

| NAME OF SCHOOL/LEAGUE/REC | DATE OF ACCIDENT/INJURY |
|---|---|

## REFERRAL INFORMATION

WHO REFERRED YOU?

◯ PHYSICIAN ◯ ATTORNEY ◯ FAMILY/FRIEND ◯ OTHER _____

| REFERRING PHYSICIAN / ATTORNEY ◯ NONE | PHONE NUMBER |
|---|---|
| ADDRESS | |

## PRIMARY CARE PHYSICIAN INFORMATION

| PRIMARY CARE PHYSICIAN ◯ NONE | PHONE NUMBER |
|---|---|
| ADDRESS | |

## EMERGENCY CONTACT

| NAME OF FRIEND OR RELATIVE | RELATIONSHIP TO PATIENT |
|---|---|
| ADDRESS | PHONE NUMBER |

## REASON FOR VISIT

WHAT IS THE REASON FOR OUR VISIT TODAY?
◯ KNEE ◯ SHOULDER ◯ HIP ◯ BACK ◯ FOOT ◯ ANKLE ◯ OTHER:

| LOCATION OF PAIN | DOMINANT HAND | HOW LONG HAS IT BEEN PRESENT? |
|---|---|---|
| ◯ RIGHT ◯ LEFT | ◯ RIGHT ◯ LEFT ◯ AMBIDEXTROUS | ◯ DAYS ◯ WEEKS ◯ MONTHS |

| HAVE YOU EVER HAD THESE SYMPTOMS BEFORE? | WHEN DOES PAIN OCCUR? |
|---|---|
| ◯ YES ◯ NO | ◯ AT REST ◯ W/ ACTIVITY ◯ AT NIGHT ◯ OTHER: |

ANY OTHER SYMPTOMS ASSOCIATED WITH CURRENT PROBLEM?

CONTEXT: HOW DID IT OCCUR?

| DATE OF INJURY | INDICATE WHAT MAKES IT BETTER |
|---|---|
| | ◯ ICE ◯ HEAT ◯ REST ◯ ELEVATION ◯ NONE |

ONSET OF CURRENT PROBLEM
◯ SUDDENLY ◯ GRADUALLY

COMPLAINT
◯ PAIN ◯ NUMBNESS ◯ SWELLING ◯ WEAKNESS ◯ OTHER:

| SEVERITY | STATUS | FREQUENCY | QUALITY |
|---|---|---|---|
| ◯ MILD | ◯ UNCHANGED | ◯ INTERMITTENT | ◯ ACHING |
| ◯ MILD / MODERATE | ◯ BETTER | ◯ OCCASIONAL | ◯ BURNING |
| ◯ MODERATE | ◯ FLUCTUATING | ◯ CONSTANT | ◯ DULL |
| ◯ MODERATE / SEVERE | ◯ IMPROVING | ◯ RARE | ◯ SHARP |
| ◯ SEVERE | ◯ WORSE | | ◯ THROBBING |
| | ◯ RESOLVED | | |

| ARE YOU EXPERIENCING RADIATING PAIN? | IF "YES", WHERE DOES THE PAIN RADIATE TO? |
|---|---|
| ◯ YES ◯ NO | |

| AGGRAVATED BY | RELIEVED BY | | ASSOCIATED SYMPTOMS / PERTINENT NEGATIVES | |
|---|---|---|---|---|
| ◯ BENDING | ◯ BRACE / SPLINT | ◯ PHYSICAL THERAPY | ◯ BRUISING | ◯ NUMBNESS |
| ◯ CLIMBING STAIRS | ◯ ELEVATION | ◯ REST | ◯ CREPITUS (CRACKING SOUNDS) | ◯ POPPING |
| ◯ DESCENDING STAIRS | ◯ EXERCISE | ◯ STRETCHING | ◯ DECREASED MOBILITY | ◯ SPASMS |
| ◯ LIFTING | ◯ HEAT | | ◯ DIFFICULTY GOING TO SLEEP | ◯ SWELLING |
| ◯ MOVEMENT | ◯ ICE | | ◯ INSTABILITY | ◯ TINGLING: ARMS |
| ◯ PUSHING | ◯ INJECTION | | ◯ LIMPING | ◯ TINGLING: LEGS |
| ◯ SITTING | ◯ MASSAGE | | ◯ LOCKING | ◯ TENDERNESS |
| ◯ STANDING | ◯ PAIN / RX MEDS _____ | | ◯ NIGHT PAIN | ◯ WEAKNESS |
| ◯ WALKING | ◯ MOBILITY | | ◯ NIGHT-TIME AWAKENING | ◯ THROBBING |
| ◯ OTHER _____ | ◯ OTC MEDS _____ | | ◯ OTHER _____ | |

## MEDICATIONS, VITAMINS, SUPPLEMENTS AND HERBS

PLEASE LIST ALL MEDICATIONS, VITAMINS, SUPPLEMENTS AND HERBS YOU ARE CURRENTLY TAKING, INCLUDING DOSAGE IN THE LINES BELOW.

| NAME | DOSAGE/AMOUNT |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## PATIENT MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY.

- ◯ ALCOHOLISM
- ◯ ALZHEIMER'S DISEASE
- ◯ ANEMIA
- ◯ ANGINA
- ◯ ARTHRITIS
- ◯ ASTHMA
- ◯ ATRIAL FIBRILLATION
- ◯ BENIGN PROSTATIC HYPERTROPHY
- ◯ CANCER
- ◯ CEREBROVASCULAR ACCIDENT (STROKE)
- ◯ CONGESTIVE HEART FAILURE (CHF)
- ◯ COPD (EMPHYSEMA)
- ◯ CORONARY ARTERY DISEASE
- ◯ CROHN'S DISEASE
- ◯ DEGENERATIVE JOINT DISEASE
- ◯ DEPRESSION
- ◯ DIABETES
- ◯ DRUG ABUSE
- ◯ DVT (BLOOD CLOT)
- ◯ FIBROMYALGIA
- ◯ GALLBLADDER DISEASE
- ◯ GERD
- ◯ GOUT
- ◯ HEPATITIS
- ◯ HYPERLIPIDEMIA
- ◯ HYPERTENSION
- ◯ INFLAMMATORY BOWEL DISEASE
- ◯ JUVENILE RHEUMATOID ARTHRITIS
- ◯ KIDNEY DISEASE
- ◯ LIVER DISEASE
- ◯ MIGRAINE HEADACHES
- ◯ MULTIPLE SCLEROSIS
- ◯ MYOCARDIAL INFARCTION (HEART ATTACK)
- ◯ OBESITY
- ◯ OSTEOARTHRITIS
- ◯ OSTEOPOROSIS
- ◯ PARKINSON DISEASE
- ◯ PEPTIC ULCER DISEASE
- ◯ PSORIASIS
- ◯ PVD
- ◯ RENAL DISEASE
- ◯ RHEUMATOID ARTHRITIS
- ◯ SCOLIOSIS
- ◯ SEIZURE DISORDER
- ◯ SLEEP APNEA
- ◯ SLE (LUPUS)
- ◯ SPINAL STENOSIS
- ◯ THYROID DISEASE
- ◯ VALVULAR DISEASE
- ◯ NONE OF THE ABOVE
- ◯ OTHER _____

## SURGICAL HISTORY

PLEASE SELECT ALL PAST ORTHOPAEDIC SURGERIES YOU HAVE HAD. ◯ NO PRIOR SURGERY

| TYPE OF SURGERY | | | | COMPLICATIONS, IF ANY |
|---|---|---|---|---|
| ◯ ANKLE | ◯ RIGHT | ◯ LEFT | DATE _____ | |
| ◯ FOOT | ◯ RIGHT | ◯ LEFT | DATE _____ | |
| ◯ HIP | ◯ RIGHT | ◯ LEFT | DATE _____ | |
| ◯ KNEE | ◯ RIGHT | ◯ LEFT | DATE _____ | |
| ◯ SHOULDER | ◯ RIGHT | ◯ LEFT | DATE _____ | |
| ◯ WRIST / HAND | ◯ RIGHT | ◯ LEFT | DATE _____ | |
| ◯ BACK | DATE _____ | | | |

| OTHER / NON-ORTHOPAEDIC SURGERY? | IF "YES", DESCRIBE |
|---|---|
| ◯ YES / DATE _____ ◯ NO | |

| HAVE YOU EVER HAD GENERAL ANESTHESIA? | HAVE YOU EVER HAD ANY PROBLEMS WITH ANESTHESIA? | IF "YES", DESCRIBE |
|---|---|---|
| ◯ YES ◯ NO | ◯ YES ◯ NO | |

## ALLERGIES

PLEASE CHECK ALL ALLERGIES THAT APPLY.

| | | | | | |
|---|---|---|---|---|---|
| ◯ ADHESIVE TAPE | ◯ IODINE | ◯ LATEX | ◯ SEASONAL | ◯ EGGS | ◯ METAL |
| ◯ CONTRAST DYE | ◯ AUTO IMMUNE | ◯ NONE | ◯ OTHER _____ | | |

## REVIEW OF SYSTEMS

ARE YOU CURRENTLY HAVING OR HAVE YOU HAD PROBLEMS WITH YOUR: (IF YES, MARK CIRCLE TO LEFT OF SYMPTOMS THAT APPLY)

| | | |
|---|---|---|
| CONSTITUTIONAL | ◯ YES ◯ NO | ◯ FATIGUE ◯ HEADACHE ◯ FEVER ◯ WEIGHT LOSS ◯ OTHER: |
| EYES | ◯ YES ◯ NO | ◯ GLASSES ◯ BLURRED VISION ◯ OTHER: |
| EARS,NOSE,THROAT | ◯ YES ◯ NO | ◯ CONGESTION ◯ HEARING LOSS ◯ JAW DISCOMFORT ◯ OTHER: |
| RESPIRATORY / LUNGS, BREATHING | ◯ YES ◯ NO | ◯ COUGH ◯ WHEEZING ◯ SHORTNESS OF BREATH ◯ OTHER: |
| CARDIOVASCULAR / HEART | ◯ YES ◯ NO | ◯ CHEST PAIN ◯ CYANOSIS (BLUE COLORATION OF SKIN) ◯ HEART MURMURS ◯ IRREGULAR HEARTBEAT ◯ OTHER: |
| GASTROINTESTINAL | ◯ YES ◯ NO | ◯ NAUSEA ◯ VOMITING ◯ STOMACH ACHES ◯ CONSTIPATION ◯ DIARRHEA ◯ OTHER: |
| RENAL / URINARY / BLADDER | ◯ YES ◯ NO | ◯ DYSURIA (PAINFUL URINATION) ◯ HEMATONIA (BLOOD IN URINE) ◯ INCONTINENCE ◯ URINARY TRACT INFECTION ◯ DIFFICULTY URINATING ◯ OTHER: |
| METABOLIC / ENDOCRINE | ◯ YES ◯ NO | ◯ DIABETES ◯ THYROID PROBLEMS ◯ DELAYS IN GROWTH ◯ OTHER: |
| MUSCULOSKELETAL | ◯ YES ◯ NO | ◯ JOINT PAIN ◯ LEG PAIN ◯ HISTORY OF BROKEN BONES ◯ OTHER: |
| HEMATOLOGIC / BLOOD | ◯ YES ◯ NO | ◯ BLEEDING ◯ ANEMIA ◯ PROLONGED BLEEDING AFTER CUT / INJURY ◯ OTHER: |
| NEUROLOGICAL | ◯ YES ◯ NO | ◯ SEIZURE ◯ DIZZINESS ◯ NUMBNESS / TINGLING ◯ HEADACHES ◯ FREQUENT FALLS ◯ OTHER: |
| INTEGUMENTARY / SKIN | ◯ YES ◯ NO | ◯ LESIONS / WOUNDS ◯ RASHES ◯ SKIN DISORDERS ◯ CONNECTIVE TISSUE DISORDERS ◯ OTHER: |
| PSYCHIATRIC | ◯ YES ◯ NO | ◯ CHANGE IN MOOD OR BEHAVIOR ◯ CHANGE IN SLEEP PATTERNS ◯ OTHER: |
| IMMUNOLOGIC / ALLERGIC | ◯ YES ◯ NO | ◯ FOOD ALLERGIES ◯ ASTHMA ◯ HAY FEVER ◯ CHRONIC RASHES ◯ COMMUNICABLE DISEASES ◯ OTHER: |
| ◯ NONE OF THE ABOVE | | |

| | |
|---|---|
| DO YOU HAVE A HISTORY OF INFECTION WITH A BACTERIA CALLED MRSA?<br>◯ YES ◯ NO | DATE TREATED |

## PATIENT'S FAMILY HISTORY

PLEASE INDICATE ANY MAJOR CONDITIONS/ILLNESSES FOR FAMILY MEMBERS BELOW.

| | | | | | |
|---|---|---|---|---|---|
| BLEEDING DISORDERS<br>◯ YES ◯ NO | BLOOD CLOTS<br>◯ YES ◯ NO | CANCER<br>◯ YES ◯ NO | DIABETES<br>◯ YES ◯ NO | GOUT DISORDERS<br>◯ YES ◯ NO | HEART DISEASE<br>◯ YES ◯ NO |
| RHEUMATOLOGIC DISORDERS<br>◯ YES ◯ NO | | FAMILY HISTORY OF CHRONIC / INHERITED DISEASES | | | |
| IS YOUR FATHER LIVING?<br>◯ YES ◯ NO | IF "NO", CAUSE OF DEATH? | | IS YOUR MOTHER LIVING?<br>◯ YES ◯ NO | IF "NO", CAUSE OF DEATH? | |

## SOCIAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| OCCUPATION | | HOME<br>◯ 1 STORY ◯ 2 STORY ◯ ENTRANCE STEPS ◯ ELEVATOR | | | |
| ACTIVITY LEVEL<br>◯ SEDENTARY ◯ MODERATE ◯ VIGOROUS | EXERCISE REGULARLY?<br>◯ YES ◯ NO | INVOLVED IN SPORTS?<br>◯ YES ◯ NO | | | |
| ARE YOU A TOBACCO USER? ◯ FORMER / YEAR QUIT _____<br>◯ CIGARETTES ◯ CIGARS ◯ SMOKELESS TOBACCO ◯ OTHER: | | AVERAGE PER DAY | NUMBER OF YEARS | IF NO, EVER?<br>◯ YES ◯ NO | |
| DO YOU CONSUME ALCOHOL?<br>◯ YES ◯ NO ◯ FORMER / YEAR QUIT _____ | AVERAGE PER WEEK | IF NO, EVER?<br>◯ YES ◯ NO | DO YOU CURRENTLY USE DRUGS?<br>◯ YES ◯ NO ◯ FORMER / YEAR QUIT _____ | | |

## ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am fully responsible for all charges incurred, regardless of my insurance status, for professional services rendered.

| | |
|---|---|
| SIGNATURE: PATIENT OR AUTHORIZED REPRESENTATIVE | DATE |
| PHYSICIAN'S INITIALS | DATE |

## PICTURES AND AUDIO/VISUAL RECORDING ACKNOWLEDGEMENT

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| | |
|---|---|
| NAME OF PATIENT (PRINT) | SIGNATURE |
| RELATIONSHIP TO PATIENT | DATE |