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		ETHNIC IDENTITY: CAUCASIAN, AFRICAN AMERICAN, HISPANIC/LATINO, ASIAN, NATIVE AMERICAN, MIDDLE EASTERN, PACIFIC ISLANDER, OTHER
EMPLOYMENT STATUS: FULL-TIME, PART-TIME, HOMEMAKER, UNEMPLOYED, FULL-TIME STUDENT, PART-TIME STUDENT, RETIRED, DISABLED		
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
RIGHT LEFT

DOMINANT HAND
RIGHT LEFT AMBIDEXTROUS

HOW LONG HAS IT BEEN PRESENT?
DAYS WEEKS MONTHS

HAVE YOU EVER HAD THESE SYMPTOMS BEFORE?
YES NO

WHEN DOES PAIN OCCUR?
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?
YES NO

IF "YES", WHERE DOES THE PAIN RADIATE TO?

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

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?
YES / DATE ______________ NO

IF "YES", DESCRIBE

HAVE YOU EVER HAD GENERAL ANESTHESIA?
YES NO

HAVE YOU EVER HAD ANY PROBLEMS WITH ANESTHESIA?
YES NO

IF "YES", DESCRIBE

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? YES NO	DATE TREATED

PATIENT'S FAMILY HISTORY

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

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

SOCIAL HISTORY

<table>
<tr><td colspan="3">OCCUPATION</td><td colspan="3">HOME
1 STORY 2 STORY ENTRANCE STEPS ELEVATOR</td></tr>
<tr><td colspan="2">ACTIVITY LEVEL
SEDENTARY MODERATE VIGOROUS</td><td colspan="2">EXERCISE REGULARLY?
YES NO</td><td colspan="2">INVOLVED IN SPORTS?
YES NO</td></tr>
<tr><td colspan="3">ARE YOU A TOBACCO USER? FORMER / YEAR QUIT ______________
CIGARETTES CIGARS SMOKELESS TOBACCO OTHER:</td><td>AVERAGE PER DAY</td><td>NUMBER OF YEARS</td><td>IF NO, EVER?
YES NO</td></tr>
<tr><td>DO YOU CONSUME ALCOHOL?
YES NO FORMER / YEAR QUIT ________</td><td>AVERAGE PER WEEK</td><td>IF NO, EVER?
YES NO</td><td colspan="3">DO YOU CURRENTLY USE DRUGS?
YES NO FORMER / YEAR QUIT ______________</td></tr>
</table>

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

Thank you for choosing **Englewood Sports Medicine Orthopaedic Surgery, P.C. ("ESMOS")** as your orthopaedic healthcare provider. We at **ESMOS** believe the physician/patient relationship is very important, which includes protecting all communication between you and your treating providers. To help in protecting your patient information, **ESMOS** prohibits the unauthorized taking of pictures and audio or visual recording while receiving care or guidance from **ESMOS** providers. If there are circumstances in which you feel that you may need to record an encounter with your **ESMOS** provider, this must be approved by the physician in writing **PRIOR TO YOUR APPOINTMENT**. Please sign below, acknowledging that you understand this policy.

NAME OF PATIENT (PRINT)	SIGNATURE
RELATIONSHIP TO PATIENT	DATE