PATIENT INFORMATION

PATIENT NAME Last First MI	SOCIAL SECURITY NUMBER	MARITAL STATUS

ADDRESS Street City State Zip

GENDER	OCCUPATION	EMPLOYER	DATE OF BIRTH (mm/dd/yyyy)

Home phone	Cell phone	Work phone	E-mail

PREFERRED CONTACT: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-Mail

REFERRING PHYSICIAN AND ADDRESS

PRIMARY CARE PHYSICIAN (IF DIFFERENT FROM ABOVE)

Dominant Hand: Right or Left **Male/Female** **Height:** **Weight:** **Age:**

How did you hear about us?

PRESENT PROBLEM

Reason for today's visit:	Date Symptoms began:

Body Part: ❑ Left ❑ Right ❑ Shoulder ❑ Elbow ❑ Wrist ❑ Hand ❑ Hip ❑ Knee ❑ Ankle ❑ Foot ❑ Neck ❑ Back

How did problem start: ❑ No injury ❑ Gradual ❑ Sudden ❑ Injury ❑ Accident ❑ Sport

If there was an injury, where did the injury occur? ❑ Work ❑ Auto ❑ Home ❑ Other Date of injury:________________

Description of injury:

Did you go to an emergency room or urgent care? ❑ Yes ❑ No **Where?**

Prior Treatments: ❑ Medications ❑ Physical therapy ❑ Injections ❑ Bracing, cast or splint ❑ Surgery ❑ Imaging

Prior Imaging: ❑ X-ray ❑ MRI ❑ CT scan ❑ Bone scan ❑ Nerve Testing

Other Treatments:

How Severe is your pain on a scale of 0-10 No pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst Pain

Severity of the Pain: ❑ Mild ❑ Moderate ❑ Severe

Is your pain: ❑ Constant ❑ Intermittent ❑ Varies

Quality of the Pain: ❑ Sharp ❑ Dull ❑ Burning ❑ Throbbing ❑ Constant ❑ Aching ❑ Stabbing

Pain Description: ❑ Constant ❑ Intermittent (Comes and Goes)

Pain at Night: ❑ Yes ❑ No

Associated Symptoms: ❑ Swelling ❑ Bruising ❑ Numbness ❑ Tingling ❑ Weakness ❑ Locking or catching ❑ Giving Away

Context of Pain: ❑ Getting Better ❑ Getting Worse ❑ Staying the same ❑ Recurrent

Timing of the Pain: ❑ Day ❑ Night ❑ Rest ❑ Work ❑ Exercise

What makes your pain better?	What makes your pain worse?

Symptoms Improved ❑ Rest ❑Elevation ❑ Ice ❑ Medications ❑ Other:

Symptoms Worsened: ❑ lifting ❑ Standing ❑ Walking ❑ Twisting ❑ Stairs ❑ Squatting ❑ Exercise ❑ Other:____________

MEDICAL HISTORY

Allergies to medicines:

Current medications:	Name	Dose	Frequency		Name	Dose	Frequency
(Please attach med list if more space is required)							

Medications tried in the past for this problem:

Previous surgeries:

MEDICAL HISTORY (CONTINUED)

Do you have any of the following?

❑Anxiety	❑Depression	❑Heart disease	❑MRSA infections
❑Breathing problems	❑Diabetes	❑Hepatitis	❑Rheumatoid arthritis
❑Atrial fibrillation	❑Blood clots	❑High blood pressure	❑Stroke
❑Bleeding disorder	❑Seizures	❑High cholesterol	❑Dental problems
❑Cancer (Type:________________)	❑Stomach disease	❑HIV/AIDS	❑Fibromyalgia
❑Heart Failure	❑Gout	❑Kidney disease	❑Osteoarthritis
❑COPD	❑Heart attack	❑Liver disease	
❑Pulmonary embolism	❑Pneumonia	❑Skin problems	

Please list any other medical problems:

FAMILY HISTORY

Do any of your close relatives have?

❑Cancer (Type:_______________)	❑Heart disease	❑Bleeding disorders	❑Blood clots
❑Stroke	❑High blood pressure	❑Diabetes	❑Other:_________________

REVIEW OF SYSTEMS

Do you have any of the following?

Constitutional: ❑ Fevers ❑ Chills ❑ Weight loss ❑ Weight Gain

Skin: ❑ Rashes ❑ Bruising ❑ Ulcers ❑ Itching ❑ Redness

Gastrointestinal: ❑ Heartburn or ulcers ❑ Nausea ❑ Vomiting ❑ Diarrhea ❑ Bloody stools

Endocrine: ❑ Diabetes ❑ Thyroid disease ❑ Heat or cold intolerance ❑ Excessive thirst or urination

Eye: ❑ Blurred vision ❑ Double vision ❑ Vision loss ❑ Corrective lenses

ENT: ❑ Hearing loss ❑ Hoarseness ❑ Trouble swallowing

Cardiovascular: ❑ Chest pain ❑ Palpitations ❑Fainting ❑ Murmurs

Respiratory: ❑ Cough ❑ Shortness of breath ❑ Wheezing ❑ Snoring

Genitourinary: ❑ Painful Urination ❑ Blood in the urine ❑ Incontinence ❑ Difficult urination

Neurologic: ❑ Headaches ❑ Dizziness ❑ Seizures ❑ Weakness ❑ Tremors ❑ Numbness/Tingling

Psychiatric: ❑ Depression ❑ Drug/alcohol addiction ❑ Sleeping disorder ❑ Hallucinations

Hematologic: ❑ Easy bleeding ❑ Easy bruising ❑ Anemia

Musculoskeletal: ❑ Joint Pain ❑ Swelling ❑ Stiffness ❑ Instability ❑ Muscle pain ❑ Redness ❑ Heat

ARE YOU POSITIVE or HAVE YOU BEEN EXPOSED TO: ❑ HIV ❑ AIDS ❑ Hepatitis C

SOCIAL HISTORY

Smoking status: ❑Nonsmoker ❑Current smoker ❑Former smoker (year quit: _______)

Do you drink alcohol? ❑Yes ❑No How many drinks? How often? Do you use any illegal drugs? ❑Yes ❑No

Are you Working? ❑Yes ❑No Where? Occupation?

SIGNATURES

SIGNATURE OF PATIENT	**Date:**
SIGNATURE OF PERSON FILLING OUT THIS FORM (IF DIFFERENT FROM ABOVE)	**Date:**

PLEASE DO NOT WRITE BELOW THIS LINE (OFFICE USE ONLY)

PHYSICIAN SIGNATURE	**Date**

OrthoNeuro Authorizations and Financial Policy

Section 1: Appointment of Personal Representative to Receive Protected Health Information

You may rely upon your spouse, relatives or friends to be involved in your medical care. OrthoNeuro can disclose your Protected Health Information to these people if you appoint them as your "personal representatives." To appoint an individual as your personal representative, complete this section:

I hereby appoint the following individual as my personal representative:

Name: ______________________________ **Relationship to me:** ____________________

I hereby authorize OrthoNeuro to disclose the following Protected Health Information to my personal representative:

- ☐ All Protected Health Information

OR One or more of these choices:

- ☐ Times of Appointments
- ☐ Test Results
- ☐ Prescriptions & Ancillary Equipment
- ☐ Copies of Medical Records
- ☐ Other ____

I may revoke my appointment of a personal representative at any time in writing. I understand that revocation of my appointment will NOT affect any action OrthoNeuro took in reliance on my appointment before it received written notice of my revocation. **Please initial:** _________

Section 2: Receipt of Notice of Privacy Practices

I hereby acknowledge receiving a copy of OrthoNeuro's Notice of Privacy Practices that outlines my privacy rights and explains how OrthoNeuro is permitted to use and disclose my Protected Health Information. I should call OrthoNeuro's Privacy Officer at (614) 890-6555 if I have a question or concern about my privacy rights. **Please initial:** _________

Section 3: Patient Information

Race: ____________________ Ethnicity: ____________________ Date of Birth: __________

Language: ____________________ Social Security Number: ____________________

Emergency Contact: ____ Phone Number: _________

Section 4: Photography and Recording Policy

Patients, family members, and other visitors shall not take photographs and shall not record video or audio in OrthoNeuro's offices.

This policy includes recording an individual's voice using technology capable of capturing audio and recording an individual's likeness using photography, video recording or any technology capable of capturing an image. **Please initial:** ________

Section 5: Financial Policy

I have reviewed OrthoNeuro's Financial Policy and Authorizations (collectively, the "Financial Policy"), hereby acknowledge my responsibilities set forth in the Financial Policy, and hereby make the authorizations set forth in the Financial Policy. Please initial: _________

By signing below, I am acknowledging that I have read and understand the financial policy and authorizations of OrthoNeuro

______________________________	______________________________	__________
Patient Name (please print)	Patient Signature	Date
______________________________	______________________________	__________
If applicable, Parent/Guardian Name	If applicable, Parent/Guardian Signature	Date