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)

PRESENT PROBLEM

Reason for today's visit: | **Date Symptoms began:**

Was this a workplace injury? ❑ Yes ❑ No. If yes, date of accident and please describe. Date:

Description:

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

Is your pain? ❑ Constant ❑ Intermittent ❑ Varies

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

Do you have any recent? ❑ Fevers ❑ Chills ❑ Bowel or bladder problems ❑ Unexplained weight loss

Have you tried? ❑ Chiropractic ❑ Physical therapy ❑ Injections ❑ Braces ❑ Traction ❑ Surgery ❑ Medications

How many weeks of therapy? What body part? Approximate Dates?

Numbness

Pins and Needles
oooooooooooooo

Burning
^^^^^^^

Aching
XXXXXX

Stabbing
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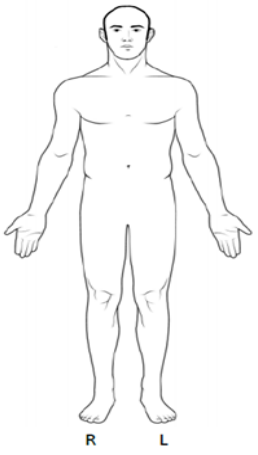

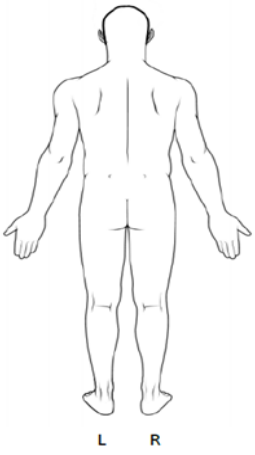

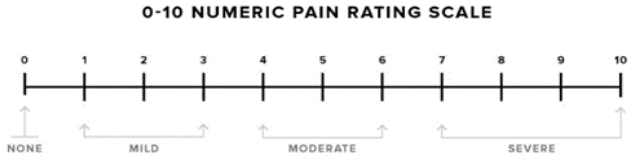

MEDICAL HISTORY

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	**Skin**	**Genitourinary**	**Cardiovascular**
❑Fevers	❑Rashes	❑Incontinence	❑Chest pain
❑Chills	❑Bruises	❑Urinary burning	❑Heart racing
❑Weight loss			❑Leg swelling

Musculoskeletal	**Hematologic**	**Gastrointestinal**	**Neurologic**
❑Joint pain	❑Excessive bleeding	❑Belly pain	❑Tingling
❑Joint swelling	❑Easy bruising	❑Reflux	❑Headache
		❑Swallowing trouble	❑Weakness

Psychiatric	**Respiratory**	**Other**
❑Anxiety	❑Shortness of breath	❑:_____
❑Depression	❑Cough	❑:_____

SOCIAL HISTORY

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

Do you use any other nicotine products? ❑Yes ❑No

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

What is your support system?

What are your exercise habits?

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
☐ Prescriptions & Ancillary Equipment
☐ Other _____
☐ Test Results
☐ Copies of Medical Records

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