

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: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, date of accident and please describe. Date:	
Description:	
If there was an injury, where did the injury occur? <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> Other	
Is your pain? <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Varies	
What makes your pain better?	What makes your pain worse?
Do you have any recent? <input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Bowel or bladder problems <input type="checkbox"/> Unexplained weight loss	
Have you tried? <input type="checkbox"/> Chiropractic <input type="checkbox"/> Physical therapy <input type="checkbox"/> Injections <input type="checkbox"/> Braces <input type="checkbox"/> Traction <input type="checkbox"/> Surgery <input type="checkbox"/> Medications	
How many weeks of therapy? What body part? Approximate Dates?	

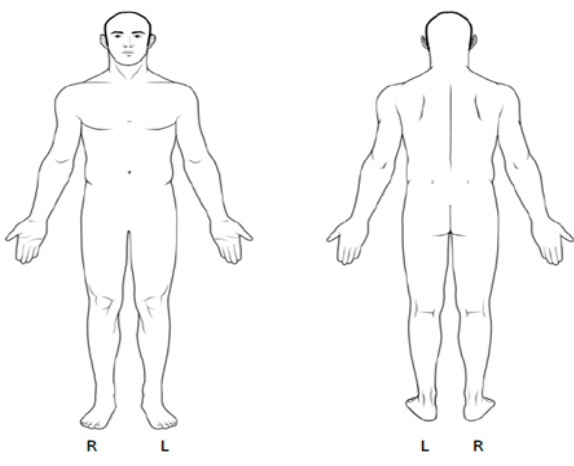
Numbness

Pins and Needles
oooooooooooooooo

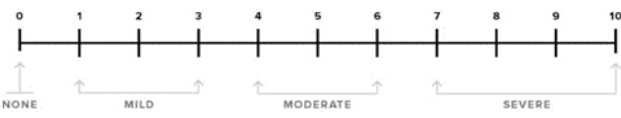
Burning
AAAAAAAAA

Aching
XXXXXXX

Stabbing
φφφφφφφ



0-10 NUMERIC PAIN RATING SCALE



MEDICAL HISTORY

Allergies to medicines:

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

Medications tried in the past for this problem:

Previous surgeries:

MEDICAL HISTORY (CONTINUED)**Do you have any of the following?**

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart disease | <input type="checkbox"/> MRSA infections |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Blood clots | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Seizures | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Cancer (Type: _____) | <input type="checkbox"/> Stomach disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Skin problems | |

Please list any other medical problems:**FAMILY HISTORY****Do any of your close relatives have?**

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Cancer (Type: _____) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other: _____ |

REVIEW OF SYSTEMS**Do you have any of the following?****Constitutional**

- Fevers
 Chills
 Weight loss

Skin

- Rashes
 Bruises

Genitourinary

- Incontinence
 Urinary burning

Cardiovascular

- Chest pain
 Heart racing
 Leg swelling

Musculoskeletal

- Joint pain
 Joint swelling

Hematologic

- Excessive bleeding
 Easy bruising

Gastrointestinal

- Belly pain
 Reflux
 Swallowing trouble

Neurologic

- Tingling
 Headache
 Weakness

Psychiatric

- Anxiety
 Depression

Respiratory

- Shortness of breath
 Cough

Other

- : _____
: _____

SOCIAL HISTORYSmoking status: Nonsmoker Current smoker Former smoker (year quit: _____)Do you use any other nicotine products? Yes NoDo 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

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