ORTHOPEDIC ASSOCIATES

Superior Access. Exceptional Care.

PATIENT INTAKE FORM

A. Patient History:

1. Name: _____ Date: _____

2. Family Doctor: _____ Consultation Requested by: _____

3. Height:_____ Weight:_____ Date of Birth: _____ Age: _____

4. Chief Complaint: _____

5. Is your problem due to an injury? ☐ Yes ☐ No Were you hurt at work? ☐ Yes ☐ No

6. What is the date of injury: ___ ___-___ ___ -___ ___ ___ ___

7. How long has your problem or pain been present? _____

8. Previous doctors seen about this problem: ☐ None

Doctor	Specialty	Date	Treatments

9. Hand Dominance: ☐ Left ☐ Right

10. Injury to: ☐ Left ☐ Right ☐ Both

Arm	☐ Shoulder	☐ Upper Arm	☐ Elbow	☐ Forearm	☐ Wrist	☐ Hand
Leg	☐ Hip	☐ Upper Leg	☐ Knee	☐ Lower Leg	☐ Ankle	☐ Foot

Other: _____

How were you injured? _____

What were you doing when you were injured? _____

Where were you when the injury occurred? _____ Please rate your pain on a scale of 1 to 10: _____

How would you describe the pain? ☐ Constant ☐ Occasional ☐ Sharp ☐ Throbbing ☐ Dull ☐ Aching ☐ Stabbing

What symptoms are you experiencing?

☐ Locking	☐ Catching	☐ Giving Way	☐ Popping
☐ Grinding	☐ Weakness	☐ Stiffness	☐ Burning
☐ Night Pain	☐ Bruising	☐ Tenderness	☐ Crunching Noise
☐ Limping	☐ Spasms	☐ Swelling	☐ Numbness
☐ Decreased Motion		☐ Difficulty Falling Asleep	
☐ Tingling in the Arms		☐ Tingling in the Legs	

What, if anything, makes your symptoms better?

☐ Brace/Splint ☐ Ice ☐ Heat ☐ Prescription Meds ☐ Physical Therapy ☐ Elevation ☐ An Injection ☐ Mobility
☐ Over-the-Counter Meds ☐ Exercise ☐ Massage ☐ Rest ☐ Stretching

Other Alleviating Factors: _____

What, if anything, makes your symptoms worse?

☐ Bending ☐ Lifting ☐ Pushing ☐ Standing ☐ Sitting ☐ Movement ☐ Walking ☐ Climbing Stairs ☐ Descending Stairs

Other Aggravating Factors: _____

Patient Name: _____

11. Treatments have included:

☐ No Medicines, Therapy, Injections, Braces, or Casts

☐ Physical Therapy or Exercise ☐ Anti-Inflammatory Meds: _____ ☐ Braces

☐ Massage or Ultrasound ☐ Narcotic Medications: _____ ☐ Traction

☐ Manipulation or Chiropractic ☐ Tens Unit ☐ Cast ☐ Cortisone Injections—how many? _____

☐ Last medication for this problem? _____

12. Tests Done/Date:

X-Ray: _____

MRI: _____

Other: _____

B. Medical History: *Please check if you have or have had any of the following:* ☐ None

☐ Stroke	☐ Heart Trouble	☐ High Blood Pressure	☐ Heart Valve
☐ Diabetes	☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Gout
☐ Osteoporosis	☐ Seizures	☐ Mental Illness	☐ Neuropathy
☐ Kidney Trouble	☐ Kidney Stones	☐ Alcoholism	☐ Hepatitis
☐ Lung Disease	☐ Serious Injuries	☐ HIV or AIDS	☐ Tuberculosis
☐ Phlebitis	☐ Anemia	☐ Acid Stomach	☐ Stomach Ulcers
☐ Liver Trouble	☐ Thyroid Trouble	☐ Bleeding Disorders	☐ Blood Transfusions
☐ Blood Clots	☐ Are you pregnant?	☐ Cancer Type of Cancer: _____	
☐ Previous Serious Infection or MRSA		☐ Metal Allergy/Sensitivity	

Please give details of those checked/list any other health problems with details:

_____

_____

_____

C. Allergies: ☐ None

_____

_____

_____

_____

Medication/Reaction: _____

D. Medications You Take: ☐ None

_____

_____

E. Surgical History: Please List Procedure/Surgeon/Date ☐ None

_____

_____

_____

Patient Name: _____

F. Family History: Please check any problems that run in your family.

☐ Stroke ☐ Heart Trouble ☐ High Blood Pressure ☐ Bleeding Disorder
☐ Diabetes ☐ Seizures ☐ Arthritis ☐ Kidney Trouble or Stones
☐ Gout ☐ Mental Illness ☐ Alcoholism ☐ Osteoporosis
☐ Cancer Type: _____

Other Family History: _____

G. Social History:

1. Work Status: ☐ Homemaker ☐ Working ☐ Unemployed ☐ Retired ☐ Disabled ☐ Medical Absence
☐ Light Duty (List Restrictions): _____

Occupation (Current or Most Recent): _____

2. Marital Status: ☐ Married ☐ Single ☐ Cohabitating ☐ Widowed ☐ Divorced
3. Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other: _____
4. Language: ☐ English ☐ Spanish ☐ Bosnia ☐ Croatian ☐ Chinese ☐ Other: _____
5. Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
6. Tobacco Use: ☐ Never ☐ Currently ☐ Formerly
Tobacco Type: ☐ Cigarettes: _____ packs per day for _____ years. ☐ Chewing ☐ Cigar ☐ Pipe
7. Alcohol Use: ☐ Never or Rare ☐ Social ☐ Alcoholic ☐ Recovering Alcoholic
8. Drug Abuse: ☐ Never ☐ Currently ☐ Formerly

Drugs Used: _____

H. Review of Systems: Please check any problem you have experienced.

☐ Reading Glasses ☐ Change of Vision ☐ Loss of Hearing ☐ Hot or Cold Spells
☐ Hoarseness ☐ Nosebleeds ☐ Difficulty Swallowing ☐ Morning Cough
☐ Fever or Chills ☐ Heart of Chest Pain ☐ Shortness of Breath ☐ Swollen Ankles
☐ Poor Appetite ☐ Frequent Rash ☐ Abnormal Heartbeat ☐ Toothache
☐ Gum Trouble ☐ Stomach Pain ☐ Calf Cramps With Walking ☐ Ulcers
☐ Diarrhea ☐ Constipation ☐ Frequent Belching ☐ Hemorrhoids
☐ Blackouts ☐ Nausea or Vomiting ☐ Frequent Headaches ☐ Seizures
☐ Ear Pain ☐ Nervous Exhaustion ☐ Recent Weight Change ☐ Frequent Urination
☐ Get Up Often at Night to Urinate ☐ Difficulty Starting Urination ☐ Burning Urination

Other: _____

If you check yes to any of the above, have you discussed the problem with your primary care physician? ☐ YES ☐ NO

Reviewed by Patient: _____ ☐ Date: _____

Reviewed by Physician: _____ ☐ Date: _____