

Patient Registration Form

Please Complete Both Sides Entirely

www.orthoneuro.com

Today's Date: _____

Last Name: _____		First Name: _____		M.I.: _____	
Address: _____		City: _____		State: _____ Zip: _____	
Home Phone: (____) _____ - _____		Cell Phone: (____) _____ - _____		Other: (____) _____ - _____	
Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female	SS#: _____ - _____ - _____		Date of Birth: ____/____/____	
Marital Status: <input type="checkbox"/> Single		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other _____
Are you employed? <input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired	<input type="checkbox"/> Other _____
Employer: _____		Employer Phone: (____) _____ - _____			
Are you a student? <input type="checkbox"/> Yes		<input type="checkbox"/> No	Name of School: _____		
Spouse's Name: _____		SS#: _____ - _____ - _____		Date of Birth: ____/____/____	
Emergency Contact: _____		Phone: (____) _____ - _____		Relation to Patient: _____	

If the patient is a minor under age 18, please list the responsible party.

Last Name: _____		First Name: _____		Relation to Patient: _____	
Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female	SS#: _____ - _____ - _____		Date of Birth: ____/____/____	
Address: _____		City: _____		State: _____ Zip: _____	
Home Phone: (____) _____ - _____		Cell Phone: (____) _____ - _____		Other: (____) _____ - _____	
Marital Status: <input type="checkbox"/> Single		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other _____
Are you employed? <input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired	<input type="checkbox"/> Other _____
Employer: _____		Employer Phone: (____) _____ - _____			

Medical Insurance Information

Primary Insurance Company: _____		Phone: (____) _____ - _____			
Claims Address: _____		City: _____		State: _____ Zip: _____	
Subscriber ID / Policy Number: _____		Group Number: _____			
Name of Insured: _____		Insured DOB: ____/____/____			
Insured's SS#: _____ - _____ - _____		Insured Employer: _____			

Secondary Insurance Company: _____		Phone: (____) _____ - _____			
Claims Address: _____		City: _____		State: _____ Zip: _____	
Subscriber ID / Policy Number: _____		Group Number: _____			
Name of Insured: _____		Insured DOB: ____/____/____			
Insured's SS#: _____ - _____ - _____		Insured Employer: _____			

For Workers' Compensation Claims – Please complete the following:

Employer at time of injury: _____ Date of injury: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
Name of Workers' Comp Insurance Co: _____ CLAIM #: _____
Contact Person: _____ Phone: (_____) _____-_____
Doctor of record for this claim: _____

For Auto, or "Other" Insurance Claims – Please complete the following:

Date of Accident or Injury: _____ CLAIM #: _____
Auto or "Other" Insurance Company: _____ Phone: (_____) _____-_____
Claims Address: _____ City: _____ State: _____ Zip: _____
Adjuster's Name: _____ Phone: (_____) _____-_____

Is the patient allergic to any medications? Yes No If yes, please list: _____

How did you hear about us?

Yellow Pages Friend / Family Member / Patient
 Internet Website Advertisement
 Physician (please complete below) Other _____
Referred By: _____ Phone: (_____) _____-_____
Do you have a Primary Care Physician (PCP)? Yes No
Primary Care Physician: _____ Phone: (_____) _____-_____

If you have any questions, or are not sure how to answer any of these questions, please do not hesitate to ask for help.

Is this visit related to an accident or injury? Yes No
Is this visit related to an accident, injury or otherwise, related to your workplace? Yes No
Is this visit related to an accident or injury at a school event? Yes No
Is this visit related to an auto accident or injury? Yes No
Is this visit related to an accident or injury other than auto, employment, or school event? Yes No
If yes, please describe: _____

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to OrthoNeuro Consultants. I authorize OrthoNeuro Consultants to release any information, acquired in the course of my treatment, needed for my medical insurance claim(s). A photocopy of this authorization is to be considered valid as the original until revoked by me in writing. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney or other third party payor is involved with payment. I understand that I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services, and yearly deductibles. I understand that copays are expected at the time services are rendered.

I certify that the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

PATIENT INTAKE QUESTIONNAIRE DR LARRY TODD, JR, DO

Name: _____

DOB: _____ Height: _____ Weight: _____ lbs

SS#: _____ Age: _____ Sex: M/F

Referring Physician: _____

Reason for Visit: _____

Medical Problems: Please check below all the conditions that pertain to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> heart disease | <input type="checkbox"/> brain tumor | <input type="checkbox"/> panic attacks |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> meningitis | <input type="checkbox"/> depression |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> encephalitis | <input type="checkbox"/> mental illness |
| <input type="checkbox"/> stroke | <input type="checkbox"/> headaches | <input type="checkbox"/> sleep disorder |
| <input type="checkbox"/> anemia | <input type="checkbox"/> seizure/epilepsy | <input type="checkbox"/> snoring |
| <input type="checkbox"/> aneurysm | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> lung disease |
| <input type="checkbox"/> bleeding disorders | <input type="checkbox"/> sore throat | <input type="checkbox"/> bronchitis/asthma |
| <input type="checkbox"/> skin disorder | <input type="checkbox"/> glaucoma | <input type="checkbox"/> mononucleosis |
| <input type="checkbox"/> ulcer/stomach disease | <input type="checkbox"/> kidney disease | <input type="checkbox"/> hepatitis A or B |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> arthritis (osteo/rheumatoid) | <input type="checkbox"/> liver infection |
| <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> cancer (_____ type) | <input type="checkbox"/> ear infection |
| <input type="checkbox"/> HIV | <input type="checkbox"/> other (explain) _____ | |

Surgeries and hospitalizations (year, hospital/city, nature of surgery/procedure):

Medications:

Allergies to medications: _____

Patient's Name (please print)

Social History:

_____ Single	Children's Name(s)	Ages
_____ Married	_____	_____
_____ Divorced	_____	_____
_____ Widowed	_____	_____

Do you smoke? Y N If yes, _____ many packs per day
for _____ years

Have you ever smoked? Y N If yes, when did you
quit? _____

Smokeless tobacco? Y N

Do you drink alcohol? Y N If yes, _____ beers per week

Have you ever drank alcohol? Y N _____ ounces of liquor per week
_____ glasses of wine per week

Have you ever used recreational drugs? Y N If yes, list _____

Last year of school completed _____

Review of Systems: Please mark with a check if you would answer yes to any of the following questions:

- _____ Do you have a fever?
- _____ Do you have a skin rash?
- _____ Have you gained 5 or more pounds in the last 6 months? If so how much? _____ lbs.
- _____ Have you lost 5 or more pounds in the last 6 months? If so how much? _____ lbs.
- _____ Are you intolerant of heat?
- _____ Are you intolerant of cold?
- _____ Do you sweat heavily at night?
- _____ Do you have any skin lumps, cysts, or lesions? If yes, explain _____
- _____ Have you noticed any changes in your skin, teeth, hair, or nails?
- _____ Do you have eye pain, redness, or inflammation?
- _____ Are you experiencing blurry or double vision?
- _____ Have you lost vision in one or both eyes?
- _____ Do you experience dizziness or lightheadedness?
- _____ Have you ever fainted, blacked out, or passed out?
- _____ Do you have difficulties with balance or unsteadiness?
- _____ Do you have ear pain or fullness?

Patient's name (please print)

Date

(ROS continued)

- _____ Do you have hearing difficulties or ringing in your ears?
- _____ Does your face ever become numb?
- _____ Is your sense of smell or taste diminished?
- _____ Are your teeth sensitive to hot food or drinks?
- _____ Are your teeth sensitive to cold foods or drinks?
- _____ Do you have bloody sinus discharge?
- _____ Do you have sinus discharge that is mostly mucus?
- _____ Do you have chest pain?
- _____ Does your heart race?
- _____ Does your heart skip beats?
- _____ Do you become short of breath?
- _____ Do your feet or ankles swell?
- _____ Do you frequently cough up phlegm?
- _____ Do you ever cough up blood?
- _____ Do you have a persistent cough or wheeze?
- _____ Do you have pain or discomfort in your abdomen?
- _____ Has your appetite changed recently?
- _____ Have you recently had nausea or vomiting?
- _____ Do you suffer from constipation, Diarrhea or excessive gas?
- _____ Have you ever been jaundiced?
- _____ Do you have burning or pain with urination?
- _____ Do you have to urinate frequently?
- _____ Do you get up at night to urinate? If so, how many times? _____

Family History: Please check if any of the following pertain to your immediate family (brothers, sisters, mother, or father). If yes, please indicate all applicable family members.

- | | |
|---------------------------|---------------------------------|
| _____ Heart disease _____ | _____ seizure or epilepsy _____ |
| _____ cancer _____ | _____ hypoglycemia _____ |
| _____ lung disease _____ | _____ high blood pressure _____ |
| _____ headaches _____ | _____ thyroid problems _____ |
| _____ arthritis _____ | _____ high cholesterol _____ |
| _____ stroke _____ | _____ muscular disease _____ |
| _____ ulcer _____ | _____ spine problems _____ |
| _____ diabetes _____ | _____ panic attacks _____ |
| _____ brain tumor _____ | _____ mental illness _____ |

Signature

Date

*****PLEASE STOP HERE*****

Medical Assistant's Use Only: BP _____

Back Pain

If work related, DOI: _____

Employer: _____

Description of accident: _____

Onset of back pain: _____

Location (as described by patient): _____

Current pain rating (average): _____/10

At worst: _____/10

Distance comfortably walked: _____

Occupation: _____

Provocative:

Last day of work: _____

Palliative:

Leg Pain

Frequency of leg pain:

Current pain rating (average): _____/10

At worst: _____/10

% of right leg pain _____%

% of left leg pain _____%

_____ buttock	L	R	both			
_____ thigh	L	anterior	posterior	medial	lateral	
	R	anterior	posterior	medial	lateral	
_____ leg	L	anterior	posterior	medial	lateral	
	R	anterior	posterior	medial	lateral	
_____ foot	L	top	bottom	toes	heel	ankle
	R	top	bottom	toes	heel	ankle

Red Flags

_____ B & B changes _____ Fevers/chills _____ Unexplained weight loss _____ Pain awakens from sleep

Previous Pain Relief Efforts

	Effective		% Relief				
	Y	N	20	40	60	80	100
_____ PT	Y	N	20	40	60	80	100
_____ Epidural Injections	Y	N	20	40	60	80	100
_____ NSAIDs _____	Y	N	20	40	60	80	100
_____ Narcotics _____	Y	N	20	40	60	80	100

Diagnostic History

_____ X-rays (_____) _____ CT (_____)
_____ MRI (_____) _____ EMG (_____)

Patient's Name (please print)

Date

Physical Exam Template – Back Pain

- _____ 1. Gait (antalgic, widened, unsteady)
- _____ 2. Toe walk (SI)
- _____ 3. Heel walk (L4, L5)
- _____ 4. Flexion of the back _____
- _____ 5. Extension of the back _____ degrees
- _____ 6. Patellar reflexes
- _____ 7. Achilles reflexes
- _____ 8. Ankle clonus (absent, 1 beat, 2 beats, sustained)
- _____ 9. Dorsalis pedis pulses
- _____ 10. Babinski
- _____ 11. Extensor hallucis longus (L5)
- _____ 12. Peroneals (S1)
- _____ 13. Tibialis anteriors (L4)
- _____ 14. Quadriceps (L4, L3, L2)
- _____ 15. Iliopsoas (L1, L2, L3)
- _____ 16. SLR
- _____ 17. Log rolling
- _____ 18. Sensory in lower extremities
- _____ 19. Long finger flexors (C8)
- _____ 20. Intrinsic (T1)
- _____ 21. Biceps, triceps, and brachioradialis reflexes
- _____ 22. Hoffman's sign
- _____ 23. Skin markings
- _____ 24. Affect
- _____ 25. Alert and oriented x3

If hip/SI joint pain:

- _____ Patrick's/FABERE
- _____ Gaellen's sign
- _____ Pelvic compression
- _____ Stinchfield's sign

- _____ Waddell signs

Patient's Name (please print)

Date

Neck Pain

If work related, DOI: _____

Employer: _____

Description of accident: _____

Onset of back pain: _____

Location (as described by patient): _____

Current pain rating (average): ____/10

At worst: ____/10

Distance comfortably walked: _____

Occupation: _____

Provocative:

Last day of work: _____

Palliative:

Arm Pain

Frequency of arm pain:

Current pain rating (average): ____/10

At worst: ____/10

% of right arm pain ____%

% of left arm pain ____%

____ shoulder L R both

____ arm L medial lateral
R medial lateral

____ forearm L medial lateral
R medial lateral

____ fingers L thumb index middle ring small
R thumb index middle ring small

Red Flags

____ B & B changes ____ Fevers/chills ____ Unexplained weight loss ____ Pain awakens from sleep

____ Loss of dexterity ____ Loss of coordination ____ Lhermitte's sign

Previous Pain Relief Efforts

	Effective		% Relief				
____ PT	Y	N	20	40	60	80	100
____ Traction	Y	N	20	40	60	80	100
____ NSAIDs _____	Y	N	20	40	60	80	100
____ Narcotics _____	Y	N	20	40	60	80	100

Diagnostic History

____ X-rays (____) ____ CT (____)

____ MRI (____) ____ EMG (____)

Patient's Name (please print)

Date

Physical Exam Template – Back Pain

- _____ 1. Gait (antalgic, widened, unsteady)
- _____ 2. Toe walk (SI)
- _____ 3. Heel walk (L4, L5)
- _____ 4. Patellar reflexes
- _____ 5. Achilles reflexes
- _____ 6. Ankle clonus (absent, 1 beat, 2 beats, sustained)
- _____ 7. Babinski
- _____ 8. Neck flexion _____ fingerbreadths from chest
- _____ 9. Neck extension _____ degrees
- _____ 10. L. external rotation _____ degrees R. external rotation _____ degrees
- _____ 11. Spurling's sign
- _____ 12. Sensory in upper extremities
- _____ 13. Deltoids (C5)
- _____ 14. Biceps (C6)
- _____ 15. Triceps (C7)
- _____ 16. Long finger flexors (C8)
- _____ 17. Intrinsic (T1)
- _____ 18. Biceps reflex
- _____ 19. Triceps reflex
- _____ 20. Brachioradialis reflex
- _____ 21. Hoffman's sign
- _____ 22. Skin markings
- _____ 23. Waddell signs
- _____ 24. Affect
- _____ 25. Alert and oriented x3

Patient's Name (please print)

Date