

Patient Registration Form

Please Complete Both Sides Entirely

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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: _____

Physician Signature: _____

Date: _____

Ortho**Neuro**

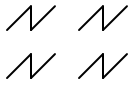
Name: _____ Date: _____ Age: _____


SS#: _____ Sex: Male _____ Female _____ DOB: _____

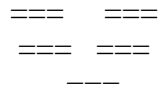
Referring Physician: _____


Referring Physician Address: _____


Mark the areas on the corresponding figures where you feel the described sensations.
Mark areas of radiation using an arrow. Include all affected areas.

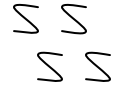
	Dull Aching
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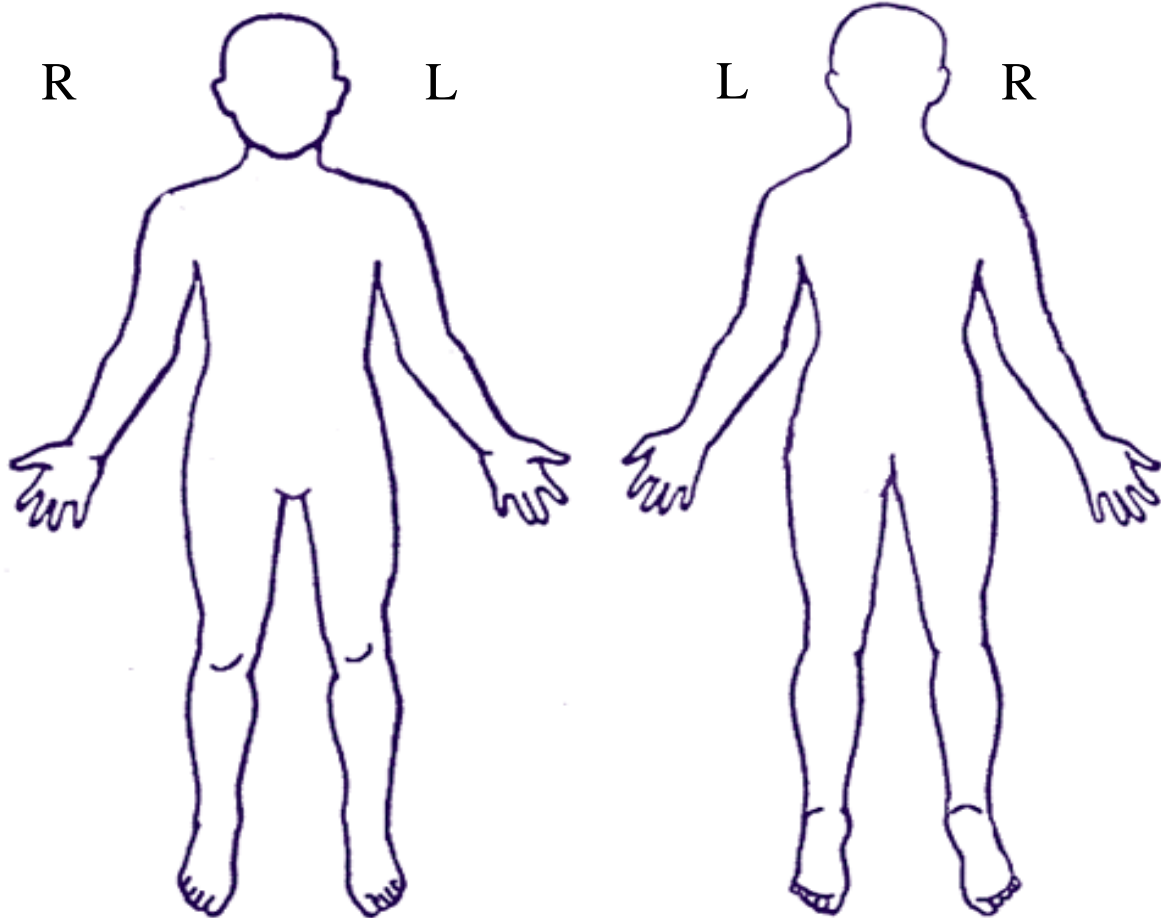
	Burning
---	---------

	Numbness
--	----------

	Stabbing
---	----------

	Pin and Needles
---	--------------------

	Muscular Cramp
--	-------------------



Please circle or mark with an X on this line the level or intensity of pain, discomfort that you are currently experiencing.

_____ / _____ / _____
 no pain pain as bad as it could be

D.) PLEASE LIST BELOW

Allergies to medication: _____

CURRENT medications for this problem (name, dose, frequency)

Other CURRENT medications: (name, dose, frequency)

Prescription and non-prescription medications taken in the PAST (indicate if it is for the current problem): _____

Other medical problems:

- | | |
|--------------------------------|---|
| _____ Heart Disease | _____ Sinusitis |
| _____ Lung Disease | _____ Ear Infection |
| _____ Cholesterol | _____ Arthritis (osteo/rheumatoid) |
| _____ Dental Disease | _____ Ulcer/Stomach Disease |
| _____ High Blood Pressure | _____ Skin Disorder |
| _____ Brain Tumor | _____ Sore Throat/Tonsillitis |
| _____ Encephalitis/ Meningitis | _____ Mononucleosis |
| _____ Headaches | _____ Lumps/Cysts |
| | _____ Deep venous Thrombosis/
Thrombophlebitis |
| _____ Thyroid problems | _____ Bleeding Disorders/Anemia |
| _____ Panic Attacks | _____ Hepatitis A or B / Liver Disease |
| _____ Mental Illness | _____ Aneurysm |
| _____ Depression | _____ Bronchitis/Asthma |
| _____ Cancer | _____ Sleep Disorder |
| _____ Stroke | _____ Seizure/Epilepsy |
| _____ Diabetes/Hypoglycemia | _____ Tuberculosis |
| _____ Glaucoma | _____ Other: explain _____ |
| _____ Kidney Disease | _____ Other: explain _____ |

Surgeries and hospitalizations (where, hospital/city, type of surgery/treatment):

E.) Check any that apply

_____ Single _____ Married _____ Divorced _____ Widowed

How many children do you have and their ages: _____

How much do you smoke per day? _____

How many years have you smoked? _____

Do you use smokeless tobacco? _____ Yes _____ No

Please indicate how much alcohol you consume:

_____ Beers per week

_____ Glasses of wine per week

_____ ounces (drinks) of liquor per week

Have you in the past or do you use recreational drugs? _____ Yes _____ No

Last year of school completed? _____

What is your support system? _____

F.) Indicate who among your **close relatives** may have any of the following ailments?

Heart Disease _____ Seizure or Epilepsy _____

Cancer _____ Brain Tumor _____

Lung Disease _____ Headaches _____

High Blood Pressure _____ Thyroid _____

Cholesterol _____ Arthritis _____

Stroke _____ Muscular Disease _____

Ulcer _____ Spine Problems _____

Diabetes _____ Panic Attacks _____

Hypoglycemia _____ Mental Illness _____

G.) Which test have you had in the past? (where, when and results)

MRI: _____

EEG: _____

Disc Injections: _____

X-Rays: _____

Bone Scan: _____

Cat Scan: _____

Myelogram: _____

EMG / Nerve Conduction Study: _____

H.) What is your height? _____ Weight? _____

I.) Review of Systems

Yes

No

Do you have a fever?

Do you have a skin rash?

Have you gained or lost weight in the last six months?

How much _____

Are you intolerant of heat or cold?

Do you sweat heavily at night?

Any skin lumps, cysts, or lesions?

Any changes in skin, hair, nail or teeth?

Do you have eye pain, redness, or inflammation?

Has your vision been blurred or doubled?

Have you ever lost vision in one or both eyes?

Do you experience dizziness or lightheadedness?

Have you ever fainted, passed out or blacked out?

Do you have difficulties with balance or unsteadiness?

Do you have ear pain or fullness?

Do you have hearing difficulties or ringing in your ears?

Does your face become numb or lose sensations?

Is your sense of smell or taste disturbed?

Are your teeth sensitive to cold, hot, or other?

Do you have sinus discharge, blood or mucus?

Do you have chest pain?

Does your heart race or skip beats?

Do you become short or breath?

Do your feet or ankles swell?

Do you cough up phlegm or blood?

Do you have a persistent cough or wheeze?

Any pain or discomfort in your abdomen?

Has your appetite changed?

Have you had nausea or vomiting?

Do you suffer from constipation, diarrhea or excess gas?

Have there been any changes in your bowel movements?

Have you been jaundiced?

Do you have burning or pain with urination?

Do you have to get up often at night to urinate?

Do you experience weakness of the arms or legs?

Any numbness or tingling of the arms or legs?

Do you have headaches or facial pain?

Do you have neck or back pain?

Do you have muscle pain or swelling?

Do you have joint pain or swelling?

Do you have difficulty with concentration or memory?

Do you often feel depressed?

Do you often feel anxious or nervous?

Do you often feel tired or sleepy?

Do you have difficulty falling asleep or staying asleep?

Do you have suicidal thoughts?

Sign Here _____

All Finished! Thank You

PHYSICAL EXAM

RR: _____ HR: _____ BP: _____

General: _____

Position / Deformities: _____

CV: Pulse, Temperature, Edema: _____

Gait: REG / Heel / Toes: _____

ROM: Ext _____

Flex _____

Lat Bend _____

Rot _____

Spasm / Tenderness / TP: _____

Shoulder / Hip: ROM, Provocation, Instability _____

Mental Status: _____

CN: _____

MSR: Knee (L3-4)
Med Ham (L5)
Ankle (S1)

Biceps (C5)
Brachioradialis (C6)
Triceps (C7)

Babinski: R _____ L _____ Hoffman: R _____ L _____

Tone: Flaccid, Cogwheel, spastic, NL): _____

Clonus: _____

Motor: Atrophy

Gastroc (S1)
EHL (L5)
Ankle inv/evert (L4/S1)
Quad (L3-4)

Biceps (C5)
ECRL+B (C6)
Triceps (C7)
Finger Flex (C8)
Finger abd (T1)

Sensory: Thigh (L3)
Medial Calf (L4)
First Dorsal Webspace (L5)
Lat Calf (S1)

Lat Shoulder (C5)
Thumb (C6)
Middle Finger (C7)
Little Finger (C8)
Medial Elbow (T1)

SLR: Sitting/Supine: Hamstrings: _____

Spurling's: _____

Tinel's: _____

Phalen's: _____

Fabere's: _____

Thigh Trust: _____

Waddell's: Overreaction

Simulation: Axial, Rotation

Distraction SLR

Regional Weakness, Sensory