Ortho*Neuro*

Demographics

Date ____________________ Social Security # ____________________

Name ____________________ Birth Date __________ Age _____ Sex: _____

Height __________ Weight __________ Last year of school completed __________

Occupation ____________________

What is the nature of today's visit: ____________________

Date accident or symptoms first occur ____________________

If an accident, where did the accident happen ____________________

If an accident, what time of day did the accident happen ____________________

Give a detailed description of accident

____

____

____

____

When did you first seek medical attention for this problem ____________________

Which test have you had in the past? (indicate where and when)

_____ MRI ____________________

_____ EEG ____________________

_____ Disc injection ____________________

_____ X-rays ____________________

_____ Bone Scan ____________________

_____ Cat Scan ____________________

_____ Other ____________________

What medications are you currently taking for this problem?

Medication	Started	Dose (mg)	benefits/adverse effects

Other medications you are currently taking

Medication	Started	Dose (mg)	benefits/adverse effects

Please list any allergies you have to medications

____

____

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Review of Systems	**Yes**	**No**
Do you have a fever?		
Do you have a skin rash?		
Have you gained or lost 5 lbs. in the last six months?		
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 double?		
Have you ever lost vision in one or both eyes?		
Do you experience dizziness or lightheadedness?		
Have you ever fainted, passed, 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 your sinuses discharge, blood or mucus?		
Do you have chest pain?		
Does you 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?		
Has there been any changes in you bowel movements?		
Have you been jaundiced?		
Do you have burning or pain with urination?		
Do you have to urinate frequently?		
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?		

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Past Medical History

Have you ever had any of the following?

_______ heart disease
_______ cancer
_______ lung disease
_______ hypertension
_______ cholesterol
_______ stroke
_______ ulcer
_______ diabetes
_______ hypoglycemia
_______ seizures/epilepsy
_______ brain tumor
_______ encephalitis
_______ meningitis
_______ headaches
_______ thyroid
_______ snoring
_______ panic attacks
_______ mental illness
_______ sinusitis
_______ ear infection
_______ bronchitis/asthma
_______ sore throat/tonsillitis
_______ arthritis
_______ anemia
_______ dental disease
_______ skin disorder
_______ sleep disorder
_______ mononucleosis
_______ glaucoma
_______ lumps/cysts
_______ deep venous thrombosis
_______ bleeding disorder
_______ tuberculosis
_______ hepatitis A or B
_______ aneurysm
_______ other (explain)

____

If you are a women age 65 or older…

Have you been screened (DXA scan) for osteoporosis since you turned 60 years old? ◻ Y ◻ N

If yes, what was the result of the testing? ______________________________

Have you been prescribed medication to prevent or treat osteoporosis? ◻ Y ◻ N

If yes, what medication are you taking? ______________________________

Please list all prescription and non-prescription medications you have taken in the past (please indicate if the medication was for your current problem):

Medication	Dose (mg)	How many pills per day	Current problem (yes)

Please list surgeries and hospitalization

year	hospital/City	Type of surgery/treatment

OB/GYN

At what age did your menstrual cycle begin? __________ stop? __________

Are your cycles regular? _______ yes _______ no

Do you experience any menstrual related problems? _______ yes _______ no

If yes, explain ______________________________

Method of birth control? ______________________________

How many pregnancies? __________ How many births? __________

Were they any complications related to pregnancy, labor or delivery? ______________________________

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Social History

Check any that apply

_______ single _______ married _______ divorced _______ widowed

Children's names and ages

____

____

____

____

Have you ever smoked tobacco? _____ yes _____ no

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 now use illicit drugs? ___________ yes ___________ no

Family History

Indicate who among your close relatives may have had any of the following ailments.

heart disease	______________________	seizures/epilepsy	______________________
cancer	______________________	brain tumor	______________________
lung disease	______________________	headaches	______________________
hypertension	______________________	thyroid	______________________
cholesterol	______________________	arthritis	______________________
stroke	______________________	muscular disease	______________________
ulcer	______________________	snoring	______________________
diabetes	______________________	panic attacks	______________________
hypoglycemia	______________________	mental illness	______________________

Physician comments:

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Patient Signature: ______________________________ **Date:** ______________

Physician Signature: ______________________________ **Date:** ______________

AUTHORIZATIONS

Section 1: 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: _________

Section 2: 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 3: 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 4: Patient Information

Race: ______________________ Ethnicity: ______________________ Date of Birth: ______________________

Language: ______________________ Social Security Number: ______________________

Emergency Contact: ______________________________________ Phone Number: ______________________

By signing below, I am acknowledging that I have read and understand this form.

Patient Name (please print)	Patient Signature	Date
If applicable, Parent/Guardian Name (Please Print)	If applicable, Parent/Guardian Signature	Date