DOB: _____ Age: _____

Which doctor sent you here? _____ Family Doctor: _____

HISTORY OF PRESENT ILLNESS

What is the problem that brought you here? _____

_____

_____

When did this begin/ approximate duration? _____

How did it occur? (circle all that apply) Lifting Twisitng Bending Fall Overuse Injury Unknown

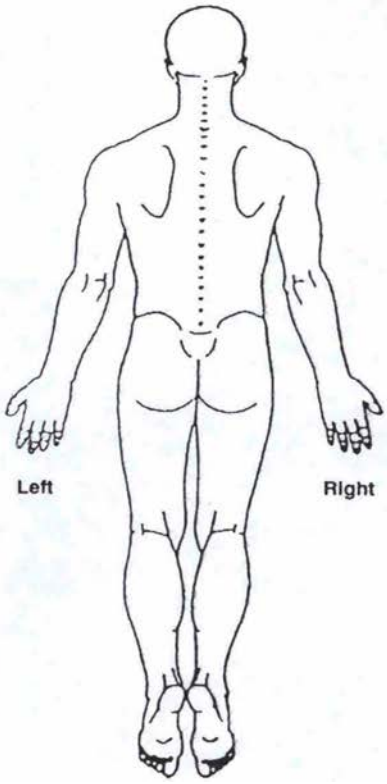
If injury, please describe: _____

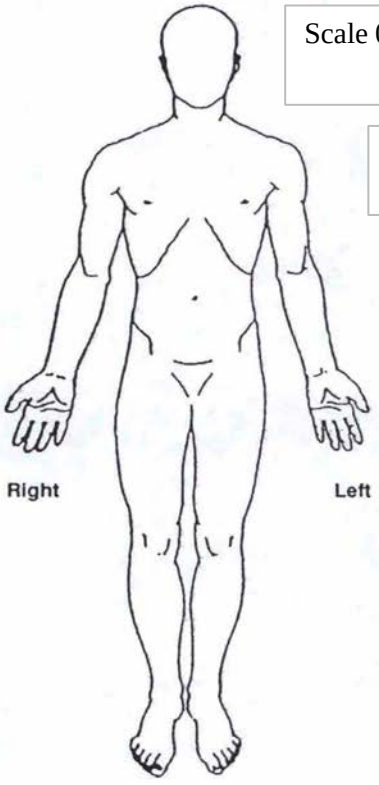
Use the appropriate symbol to mark all affected areas on your body where you feel the described sensations and areas of radiation. Just to complete the picture, please draw in your face.

A or	≈≈≈	Aches
N or	□□□	Numbness
B or	XXXXX	Burning
P or	oooo	Pins & Needles
S or	ΔΔΔΔ	Stabbing

Pain in arm(s) compared to neck:
- ☐ Worse than neck
- ☐ Same as neck
- ☐ Less than neck

Pain in leg(s) compared to back:
- ☐ Worse than back
- ☐ Same as back
- ☐ Less than back





Scale 0-10: 0= no pain
10=worse pain of my life

Good Day: ___/10
Bad Day: ___/10

Severity:
___ mild
___ moderate
___ severe

Frequency:
___ intermittent
___ constant

Pain is:
___ increasing
___ the same
___ improving

Worsened by: ____ bending ____ standing ____ walking ____ sitting ____ lying down ____ nothing

Improved by: ____ bending ____ standing ____ walking ____ sitting ____ lying down ____ nothing

Do you have difficulties completing activities of daily living? (circle all that apply) walking prolonged standing sit to stand lifting bending bathing feeding self toileting housekeeping Other: _____

Check if you have:

____ Changes in your bladder or bowel control
____ Increase of pain at night or at rest
____ Difficulty walking
____ Balance Problems
____ History of Cancer
____ Fever or chills
____ Unexplained weight loss
____ Numbness/Weakness
____ Grip Strength

Treatments:

____ NSAIDs (Motrin, Advil, Ibuprofen, Aleve, Naproxen, Celebrex, other)
How often? _____
How long did you take this medicine? _____
Did it help? Yes No

____ Physical Therapy for neck and/or back consisting of stretching and strengthening exercises
Dates/ Duration: _____
Were you given a home exercise program? Yes No
If yes, how often are you doing the exercises? _____

____ Cortisone Pills (Prednisone, "steroid tapers", etc.)
Dates/ Duration: _____
Did it help? Yes No

____ Epidural Injections
How long ago/ How many? _____
Did it help? Yes No

____ Chiropractic
How long ago/ How many treatments?
Did it help? Yes No

____ Other _____

MEDICAL HISTORY

Check if you have or
are you being treated for any of the following:

____ Yes ____ No Heart Disease
____ Yes ____ No Heart Attack Date: _____
____ Yes ____ No High blood Pressure
____ Yes ____ No Stroke/TIA Date: _____
____ Yes ____ No Blood Clots
____ Yes ____ No Sugar diabetes
____ Yes ____ No Asthma or lung disease
____ Yes ____ No TB
____ Yes ____ No Cancer: What kind: _____
____ Yes ____ No Other: _____

____ Yes ____ No Ulcers
____ Yes ____ No Blood in Stool/ Black Stool
____ Yes ____ No Arthritis
____ Yes ____ No Prostate problems
____ Yes ____ No Thyroid disease
____ Yes ____ No Kidney disease
____ Yes ____ No Liver disease
____ Yes ____ No HIV

SURGICAL HISTORY

List any previous operations and dates: _____

_____

_____

_____

_____

_____

Do you have a pacemaker? ____ Yes ____ No
Any metal in your body? ____ Yes ____ No If Yes: Where? _____
Do you have a stent? ____ Yes ____ No

MEDICATIONS

Name	Dose	Frequency

ALLERGIES

Do you have any allergies to medications? ____ Yes ____ No

If yes, list the medications and reactions: _____

_____

_____

_____

_____

SOCIAL HISTORY

Occupation (If retired, previous occupation): _____

Are you out of work or on disability? ____ Yes ____ No

Does your job entail strenuous activity? (circle all that apply)

lifting prolonged standing/walking/sitting repetitive motions other: _____

Do you use nicotine? ____ Yes If yes, Type _____ How Often? _____ How Long? _____

____ No If you have smoked in the past, when did you quit? _____

How many alcoholic drinks do you consume per week? _____ per week

Any history of recreational drug use? ____ Yes ____ No

Do you have a history of alcoholism or addiction? ____ Yes ____ No

If you are a women age 65 or older…

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

__ Yes __No If yes, what was the result of the testing? _____

Have you been prescribed medication to prevent or treat osteoporosis? __ Yes __ No

If yes, what medication are you taking? _____

REVIEW OF SYSTEMS

Check if you have any of the following symptoms?

	YES	NO		YES	NO	
GENERAL			Unexplained weight loss			Fever
			Bleeding disorder			Night sweats
			Blood transfusion			Chills
HEENT			Headaches			Dizziness
			Double Vision			Blurred Vision
			Hearing loss			
GU			Blood in urine			Prostate problems
			Pain with urination			
CARDIAC			Chest pain			Shortness of breath
			Irregular heartbeat			
NERVES			Anxiety			Seizures
			Depression			Difficulty sleeping
			Fainting			Tremor
SKIN			Rash			
GI			Constipation			Diarrhea
			Blood in stools			Nausea, vomiting
			Ulcers			Hepatitis
RESPIRATORY			Cough			Wheezing
MUSCLE/			Morning sickness			Joint swelling
JOINT/			Joint pain			Muscle tenderness
BONE			Muscle Weakness			
HEMATOLOGIC			Amenia			Easy Bruising

FAMILY HISTORY

Check if any of the following run in your family (father, mother, brother, sister):

____ Heart Disease	____ Sugar diabetes	____ Thyroid disease
____ Heart Attack	____ Asthma or lung disease	____ Kidney disease
____ High blood Pressure	____ Ulcers	____ Liver disease
____ Stroke	____ Arthritis	____ Prostate problems

____ Cancer: What kind: _____

____ Other: _____

ACCIDENT INFORMATION

Were you injured at work? ____ Yes ____ No Date it occurred? _____

Was your injury an accident? ____ Yes ____ No Where did it occur? _____

Briefly describe what happened: _____

Is there a third party involved that would be responsible for payment of services incurred as the result of the accident described above? ____ Yes ____ No

If yes, Name _____ Address _____

The above information is correct an complete to the best of my knowledge:

Signed _____ / _____ Date _____

Patient/ Parent Relationship to patient

PHYSICAL EXAM

Constitutional

Vitals:

Sex _____ Male_____ Female

Height _____ ft._____ in.

Weight_____

Right/left handed _____

DO NOT FILL OUT BELOW.

NAME OF FACILITY AND DATE OF SERVICE:

General appearance:

Cardiovascular

Pulses in the extremities

Lymphatics

Nodes in neck, axillae, groin

Skin

Skin of the neck, spine, pelvis, and all extremities:

GI

Musculoskeletal ad Neurologic:

Orientation to time, person, place:

Mood and affect

Coordination:

Gait:

Cervical spine:

Inspection

Palpation

ROM

Laxity Strength

Spurling Axial compression

Thoracic/ Lumbar spine:

Inspection

Palpation

ROM

Laxity Strength

Extremities:

Inspection

ROM

Laxity

Motor strength:

Sensation:

Babinski: Clonus:

Straight left raise:

X-rays:

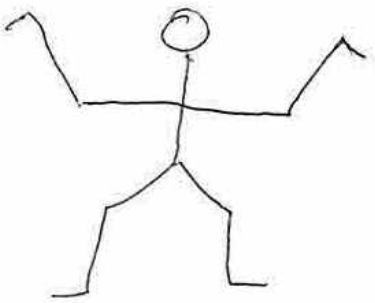
CT scan:

MRI:

Bone Scan

EMG:

Reflexes:



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