OrthoNeuro

For every motion in life.

NEW PATIENT INFORMATION

NAME: ______________________ AGE: __________ DATE: __________

REFERRING DOCTOR/THERAPIST: ______________________

SELF REFERRAL (if so, circle)

Are you: ❑ Male ❑ Female

❑ Right handed ❑ Left handed ❑ Ambidextrous

CHIEF COMPLAINT

Reason for visit: ______________________

Location of your pain:

❑ Head	❑ Shoulder	❑ Mid Back	❑ Leg	❑ Ankle/Foot	❑ Wrist/Hand
❑ Neck	❑ Headaches	❑ Low Back	❑ Knee	❑ Hips/Buttocks	❑ Arm

HISTORY OF PRESENT ILLNESS

Date of injury or symptom onset: ______________________

Type of injury: ❑ Sport Injury ❑ Job Accident

❑ Car Accident (Were you the ❑Driver or ❑Passenger? Seatbelted? ❑No ❑Yes)

❑ Other (explain): ______________________

Please describe how you injured yourself: ______________________

____

____

____

____

Please describe your current symptoms: ______________________

____

____

____

Circle the number that corresponds to the severity of your pain on a scale of 0-10.
"0" means no pain and "10" is the worst pain you can imagine.

At its worst:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10

Which of the following best describes the character of your pain:

Timing:

❑ Continuous, steady, constant
❑ Rhythmic, periodic, intermittent
❑ Brief, momentary, transient
(Frequency: _____ Duration: _________)

Quality:

❑ Throbbing ❑ Burning ❑ Superficial
❑ Aching ❑ Tingling/numbness ❑ Deep
❑ Sharp ❑ Dull ❑ ____________________

What makes your pain worse? ____________________

What makes your pain better? ____________________

How long/far can you: Sit ____________ Stand ____________ Walk ____________

Since your injury is your pain: ❑ Better ❑ Same ❑ Worse

If your pain is changed, what percentage? 10 20 30 40 50 60 70 80 90 100%

Have you had any loss of bowel or bladder control? ❑ No ❑ Yes

PREVIOUS TREATMENT

Have you had treatment since your injury? ❑ No ❑ Yes Have you been to the ER for this? ❑ No ❑ Yes
Have you had any of the following tests or procedures performed:

X-Rays? ❑ No ❑ Yes MRI? ❑ No ❑ Yes Epidurals? ❑ No ❑ Yes

CT Scan? ❑ No ❑ Yes EMG? ❑ No ❑ Yes

Other (please explain) ____________________

Medical:

Dr.__________ Date of 1st visit ____________ Last visit ____________
Diagnosis given ____________________
Medications given ____________________
Treatment provided ____________________

Chiropractic: ❑ No ❑ Yes

Dr.__________ Date of 1st visit ____________ Last visit ____________
Diagnosis given ____________________
Frequency: ❑ Every Day ❑ Three times/week ❑ Two times/week ❑ Weekly
Has it helped? ❑ No ❑ Yes

Physical Therapy: ❑ No ❑ Yes

Therapist __________ Date of 1st visit ____________ Last visit ____________
Has it helped? ❑ No ❑ Yes Home exercise program given? ❑ No ❑ Yes

CURRENT MEDICATIONS:

NAME	DOSAGE	HOW OFTEN DO YOU TAKE THIS PER DAY

MEDICATION ALLERGIES ❑ No ❑ Yes

If yes, please list:

Name	Reaction

Are you allergic or had any reaction to iodine, shellfish, IVP dye, or contrast media? ❑ No ❑ Yes

PAST MEDICAL HISTORY

❑ Anxiety ❑ Heart Attack ❑ Polio ❑ Thyroid trouble ❑ Depression ❑ Hypertension
❑ Asthma ❑ Heart Murmur ❑ Stroke ❑ High Cholesterol ❑ Alcoholism ❑ Liver disease
❑ Cancer ❑ Lung Disease ❑ Parkinson's ❑ Rheumatic Fever ❑ Hepatitis ❑ Chronic pain
❑ Diabetes ❑ Ulcers/PUD ❑ Arthritis ❑ Claustrophobia ❑ Other ________________

Have you ever had similar symptoms/injury before? ❑ No ❑ Yes

If yes, when: ______________ Please describe briefly: ______________________________

____

PAST SURGICAL HISTORY

Have you had any surgeries? ❑ No ❑ Yes

If yes, please list type of surgery and approximate date:

1. ______________ 2. ______________ 3. ______________

4. ______________ 5. ______________ 6. ______________

FAMILY HISTORY

Please check box for any medical condition that a blood relative has a history of:

❑ Anxiety ❑ Heart Attack ❑ Polio ❑ Thyroid trouble ❑ Depression ❑ Hypertension
❑ Asthma ❑ Heart Murmur ❑ Stroke ❑ High Cholesterol ❑ Alcoholism ❑ Liver disease
❑ Cancer ❑ Lung Disease ❑ Parkinson's ❑ Rheumatic Fever ❑ Hepatitis ❑ Chronic pain
❑ Diabetes ❑ Ulcers/PUD ❑ Arthritis ❑ Claustrophobia ❑ Psychiatric illness
❑ Other ________________

SOCIAL HISTORY

Marital Status: (Check one or more)

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ "Living together" ❑ Separated

Number of children: ________ Ages: ______ ______ ______ ______ ______ ______

Do you smoke? ❑ No ❑ Yes How much? ______________________

Previous Smoker? ❑ No ❑ Yes When stopped? ______________________

Do you drink alcohol? ❑ No ❑ Yes How much? ______________________

Coffee, tea, cola beverages (cups/glasses/cans per day) ______________________

Do you use recreational drugs? ❑ No ❑ Yes What type/how often? ______________________

Are you currently employed? ❑ No ❑ Yes If yes, type of job ______________________

REVIEW OF SYSTEMS: Please mark those items which you currently experience:

GENERAL

❑ Fever ❑ Weight gain ❑ Weight loss ❑ Fatigue ❑ Chills

❑ Weakness ❑ Night sweats

DERMATOLOGIC

❑ Jaundice ❑ Itching/rash ❑ Lesions ❑ Easy bruising

HEAD/HEARING & VISION

❑ Trauma ❑ Headaches ❑ Tenderness ❑ Dizziness

❑ Ringing in ears ❑ Blindness ❑ Blurred vision

❑ Changes/loss ❑ Discharge ❑ Rings around lights

❑ Double vision ❑ Light sensitivity ❑ Glasses

PULMONARY

❑ Wheezing ❑ Shortness of breath ❑ Chronic cough ❑ Coughing up blood

CARDIOVASCULAR

❑ Chest pain ❑ Leg swelling ❑ Shortness of breath with exertion ❑ Racing heart

GASTROINTESTINAL

❑ Nausea ❑ Abdominal pain ❑ Bloody stool ❑ Constipation ❑ Diarrhea

❑ Vomiting ❑ Stool color changes ❑ Heartburn ❑ Incontinence of bowels

GENITOURINARY

❑ Blood in urine ❑ Vaginal discharge ❑ Pregnancy ❑ Pain/burning on urination ❑ Incontinence

❑ Venereal disease ❑ Sexual problems ❑ Painful menstruation

❑ Menopause ❑ Urgency/frequency with urination ❑ Irregular menstruation

MUSCULOSKELETAL

❑ Arthritis ❑ Joint swelling ❑ Trauma

NEUROLOGICAL

❑ Loss of Sensation ❑ Seizures ❑ Numbness and Tingling

PSYCHOLOGICAL

❑ Sadness ❑ Anxiety ❑ Depression

Patient 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
☐ Test Results
☐ Prescriptions & Ancillary Equipment
☐ Copies of Medical Records
☐ Other ____

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