Chief Complaint

1. Which shoulder are we evaluating you for today? Right / Left

2. What is the main complaint of your shoulder? Pain / Weakness / Stiffness / Looseness / Injury

History of Shoulder Problem

1. How long have you had this problem (duration)?

2. How did your symptoms begin? (Circle One): Gradually over time / After an injury

   If there was an injury, what was the date of injury?

   Describe injury in detail:

   

Do you have a BWC work related claim? Yes / No
Are you currently working? Yes / No
Who is your employer? What is your job position?

3. What is the location of your shoulder pain? (Circle all that apply)
   Front / Back / Side / Shoulder blade area / Arm area / Neck area

4. What is the severity of your pain? (Circle one): Mild / Moderate / Severe

   On a scale of ten, with 0 being no pain and 10 being worst pain ever, how would you rate your average daily pain? (Circle one number)

   (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Worst Pain Ever)

5. What is the quality of your shoulder pain? Sharp / Dull / Burning / Throbbing / Constant

6. What is the context of your symptoms? Getting better / Getting worse / Staying same / Recurrent
7. When does the **timing** of your symptoms occur? (Circle all that apply)
   - During the day
   - At night
   - At rest
   - At work
   - With exercise
   - With overhead activity

8. What makes your shoulder better (**modifying activities**)?
   - Heat
   - Ice
   - Rest
   - Elevation
   - Pain medications
   - Cortisone injections
   - Exercise

   What makes your shoulder pain worse?
   - Overhead activity
   - Repetitive activity
   - Lifting
   - Carrying
   - Pushing
   - Pulling

9. What other **associated symptoms** are you having with your shoulder pain?

   (Circle all that apply): Numbness / Swelling / Limited movement

   Do you have neck pain? Yes / No
   Can you make your shoulder hurt by moving your neck? Yes / No
   Do you have numbness in your arm or hand? Yes / No
   Do you have upper back pain? Yes / No
   Do you have shoulder blade pain? Yes / No

10. What treatment have you had for this shoulder problem? (Check all that apply)
    - Anti-inflammatory medication / NSAIDs (If yes, list names):
    - Narcotic pain medication (If yes, list names):
    - Cortisone Injections (If yes, list when and how many):
    - Physical Therapy (If yes, list when and how long):
    - MRI (If yes, list when and where):
    - EMG/Nerve Conduction Test (If yes, list when and where):
    - Shoulder surgery (If yes, list dates, procedure, and surgeon):

**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?

I certify that the above information is fact and authorize OrthoNeuro to provide this information to my insurance company to assist in processing my medical claim in a timely manner.

Signature: _______________________________  Date: ____________________________
**Drug Allergies (List drug allergy and reaction)**

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**Current Medications (List drug, dosage, and frequency)**

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**Post Medical History (List chronic medical problems)**

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**Surgical History (List prior surgeries and year performed)**

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**Family History**

<table>
<thead>
<tr>
<th>Member</th>
<th>Living</th>
<th>Deceased</th>
<th>Age(s)</th>
<th>List any health problems and/or cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
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<tr>
<td>Mother</td>
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</tr>
<tr>
<td>Brothers</td>
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<tr>
<td>Sisters</td>
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<td></td>
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<tr>
<td>Children</td>
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**Social History**

- **Do you smoke?** Yes / No
- **Do you drink alcohol?** Yes / No
- **Marital status:** Single / Married / Divorced / Separated / Widowed
- **Occupation:**
- **Do you take recreational drugs?** Yes / No

**Review of Systems**

<table>
<thead>
<tr>
<th>System</th>
<th>Symptoms</th>
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</thead>
<tbody>
<tr>
<td>1 Constitutional</td>
<td>unexpected weight loss, weight gain, fever, chills, fatigue</td>
</tr>
<tr>
<td>2 Eyes</td>
<td>corrective lenses, blurred/double vision, eye pain, redness, watering</td>
</tr>
<tr>
<td>3 ENT</td>
<td>headache, difficulty swallowing, nose bleeds, ringing in ears, earaches</td>
</tr>
<tr>
<td>4 Cardiovascular</td>
<td>chest pain, palpitations, fainting, murmurs</td>
</tr>
<tr>
<td>5 Respiratory</td>
<td>short of breath, wheezing, cough, tightness, inspiration pain, snoring</td>
</tr>
<tr>
<td>6 Gastrointestinal</td>
<td>heartburn, nausea, vomiting, constipation, diarrhea, bloody/tarry stools</td>
</tr>
<tr>
<td>7 Genitourinary</td>
<td>frequency, urgency, difficult/painful urination, flank pain, bleeding</td>
</tr>
<tr>
<td>8 Musculoskeletal</td>
<td>joint pains, swelling, instability, stiffness, redness, heat, muscle pain</td>
</tr>
<tr>
<td>9 Skin</td>
<td>skin changes, poor healing, rash, itching, redness</td>
</tr>
<tr>
<td>10 Neurologic</td>
<td>numbness/tingling, unsteady gait, dizziness, tremors, seizures</td>
</tr>
<tr>
<td>11 Psychiatric</td>
<td>nervousness, anxiety, depression, hallucinations</td>
</tr>
<tr>
<td>12 Hematologic</td>
<td>easy bleeding, bruising</td>
</tr>
<tr>
<td>13 Endocrine</td>
<td>excessive thirst or urination, heat/cold intolerable</td>
</tr>
<tr>
<td>14 Allergic</td>
<td>reaction to foods or environment</td>
</tr>
</tbody>
</table>

**Physician Signature:** ___________________________  **Date:** ___________________________
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 __________________________