Dr. Skeels-Physical Medicine **FILL OUT COMPLETELY as possible** Today's Date ____________

How is your **Name** spelled? ______________________ Your Age ____________

What condition are you seeing Dr. Skeels for? ______________________

IMPORTANT INFORMATION: How did you hurt yourself?

❑ At Work ❑ Car or other Accident: date ________ ❑ Don't know / Not sure ❑ Other ________

When did your symptoms **first** start? ______________________ (PRIOR)

List any **Physicians** you have seen for this condition: ______________________

______________________ Who is your Family Doctor? ______________________

❑ I am **NOT WORKING at present.** If off work are you receiving payments? ______________________

❑ I am **WORKING** the same job. What do you do for work? ______________________

❑ I am **WORKING,** but different job…. ______________________

Treatments I have had so far for this **current condition:** ❑ Manipulation/Adjustments ❑ Physical Therapy

❑ Brace ❑ TENS unit ❑ Shots ❑ Traction ❑ Other ______________________

Tests I have had for this condition: ❑ MRI ❑ EMG / Nerve Tests ❑ Myelogram ❑ X-rays ❑ CAT Scan

❑ Discogram ❑ Bone Scan Other tests ______________________

If you are 65+ years old, have you been screened (DXA scan) for osteoporosis? ❑ Y ❑ N Results: ____________

Have you been prescribed medication to prevent/treat osteoporosis? ❑ Y ❑ N Meds: ____________

Other Symptoms I have: ❑ Bowel/Bladder Incontinence ❑ Increased Pain with Laying ❑ Weakness

❑ Increased pain with weather changes ❑ Increased Pain with sitting ❑ Difficulty Sleeping ❑ Painful hair

❑ Increased Pain with Walking ❑ Morning stiffness Other ______________________

GENERAL MEDICAL HISTORY

Medical History of: ❑ Bleeding ❑ Drug use ❑ Mental/Psychiatric ❑ Cancer

❑ Heart ❑ Lungs/Breathing ❑ Liver/Jaundice ❑ Diabetes ❑ High blood pressure ❑ Neurologic

❑ Seizures / Loss of consciousness ❑ Infection/Fevers ❑ Kidney/Urination ❑ Stomach/Intestinal

❑ Difficulty with anesthesia List any **Other** Medical Problems or any **Surgery** you have had: ____________

____

Your **Height** ________ **Weight** ________ Do you use **Tobacco?** ❑ YES ❑ NO (MKDA)

I have **Symptoms** of: ❑ Unexpected weight changes ❑ Frequent Soaking night sweats ❑ Definite Fever

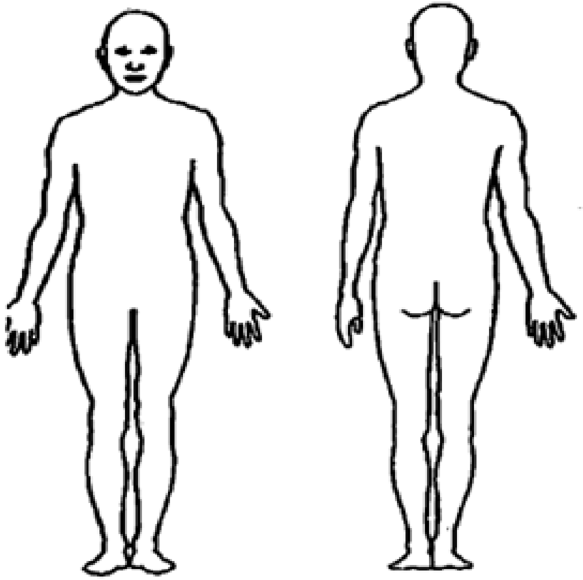
❑ Recurring Rashes ❑ Shaking Chills ❑ Joint swelling ❑ Short of Breath Other? ____________

List **ALL Medicines** you take: ❑ Non prescription pain medicine ❑ NONE ❑ Need more Room.

Names	**Dosage**	**Take how many per day?**					
		1	2	3	2 to 4	4 to 8	more
		1	2	3	2 to 4	4 to 8	more
		1	2	3	2 to 4	4 to 8	more
		1	2	3	2 to 4	4 to 8	more
		1	2	3	2 to 4	4 to 8	more
		1	2	3	2 to 4	4 to 8	more
		1	2	3	2 to 4	4 to 8	more
		1	2	3	2 to 4	4 to 8	more

Any Family Medical problems?: ❑ NONE That I know of

Father Mother Brothers



Using X's for Pain
O's for Numbness or Tingling
S's for areas of Spasm

Mark the usual locations of Pain, Numbness / Tingling, and or spasm on the Figures to the Left.

Usual Pain Scale: 0=No Pain 5 = Moderate Pain (Limits Activity) 10=Severe Pain (gone to the Hospital)

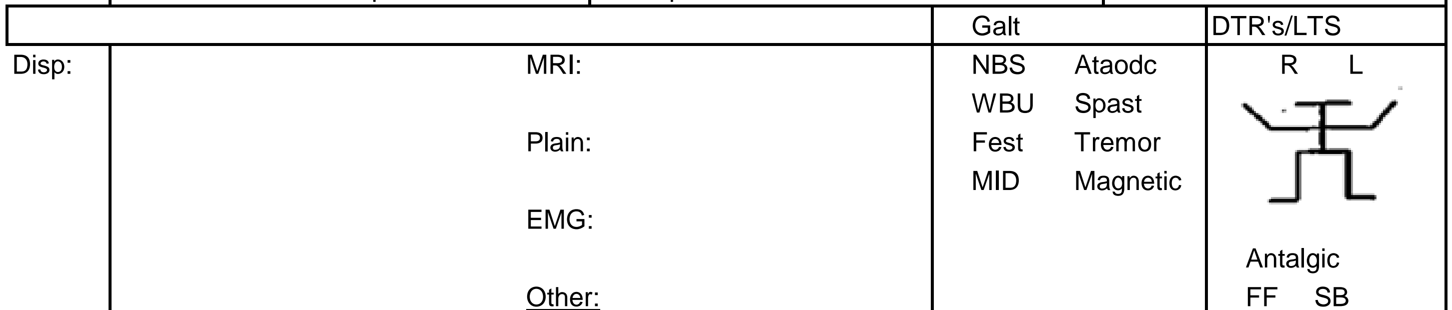
Average Daily pain experienced	0 1 2 3 4 5 6 7 8 9 10
Most Severe Pain level over the last 3 Months	0 1 2 3 4 5 6 7 8 9 10
Lowest Pain level over the last 3 Months	0 1 2 3 4 5 6 7 8 9 10
Pain level when not taking pain medicine	0 1 2 3 4 5 6 7 8 9 10

In General I Feel I am getting:

Better Worse Staying the Same

Sign here [ ]

General	Provocative omxn ❑	Motor cogwh ❑	Sensory	Palpate ❑ Hyperpathic
	SLR R HD/VS ____		P T V	spsin ❑ Axtal Compress
	L ____ DF ____			
	Femoral____ Priform ____	Fine	non dem ❑	Trgr Pt
	P/T Patricks ___I___	Atrophy DP	R PT RRR	
	CUB E			
		Adsons	Roos	FF ROT EXT SB
	CAR Spurlings:			
	Lhermittes SA/Drape Shldr ROM	Trophic SCCE	Fascic	



		Galt	DTR's/LTS
Disp:	MRI:	NBS Ataodc	R L
		WBU Spast	
	Plain:	Fest Tremor	
		MID Magnetic	
	EMG:		
			Antalgic
	Other:		FF SB

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 of 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 ______________________________ Date ____________________

All Finished! Thank You

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