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Last update 02/15/18

Academy Orthopaedic Clinic, LLC

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Date: ____/____/____ Name: _____
LAST NAME First Middle

Address: _____
Street APT# City State Zip

Telephone #'s: Hm: _____ Wk: _____ Cell:_____

Email:_____

Age:_____ Date of Birth: ____/_____/_____ Sex: _____ SSN: _____/_____/_____

Employer: _____ Occupation: _____

Spouse's Name: _____

Telephone #'s: Hm: _____ Wk: _____ Cell:_____

Pharmacy:_____ **Phone**:_____

Primary Insurance:_____ Secondary Insurance:_____

Patient Under 18 / Parent's Information

Mother's Name:_____ SSN: _____/_____/_____DOB: ___/____/____

Employer and Occupation (if applicable to insurance)_____

Telephone #'s: Hm: _____ Wk: _____ Cell:_____

Father's Name:_____ SSN: _____/_____/_____DOB: ___/____/____

Employer and Occupation (if applicable to insurance)_____

Telephone #'s: Hm: _____ Wk: _____ Cell:_____

Emergency Contact Information (not living in same home)

Name: _____ Relationship: _____

Telephone #'s: Hm: _____ Cell: _____

By signing here, you attest that you have read and agree to the **Consent to Treatment and HIPPA Compliance** form:

Signature:_____ **Date**;_____

By initialing here I attest that the information contained on this sheet is current. Pt Initials:_____ Date:_____

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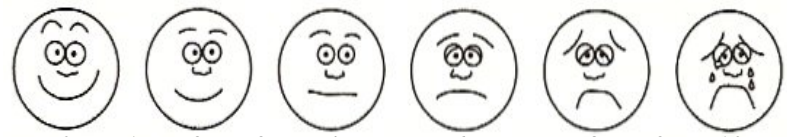
Patient Name: _____ **Date of Birth:** _____/_____/_____ **Age**_____

Name of Primary Physician: _____

Tell me about your orthopaedic problem with the following:

1 Circle the number that rates your pain. 0 is no pain, a 10 is the worst pain you could ever imagine.



2 What orthopaedic issue are you being seen for today? _____ Left /Right

- Date of accident, injury or onset of problem. _____
- Is this a re-injury or re-occurrence? ☐ yes ☐ no If yes, when?_____
- Have you been seen by another provider (outside this office) for this same problem? Yes _____No _____
- If Yes - Approx when _____ If Yes - Approx how many visits prior today's visit _____
- If yes what is your diagnoses? _____

3 When is it a problem (e.g., walking, activity) _____

4 Circle what best describes: stabbing / shooting / sharp / dull / other: _____

5 How long do the pain/ symptoms usually last: _____

6 Things you have tried to alleviate problem _____

7 Did any of these help, if so which ones: _____

8 Associated symptoms (e.g., popping / instability / swelling) _____

9 General trend in the severity of the pain since it's onset: (Circle the most appropriate answer)

- **Unchanged**
- **Increased**: Greatly Moderately Slightly
- **Decreased**: Greatly Moderately Slightly
- Is the pain: ☐Constant ☐Intermittent ☐Varies

10 Does the pain interfere with your sleep? ☐yes ☐no

D.O.S. _____/_____/_____ **MD/PA-C Signature:** _____

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Patient Medical History

Check any **PAST** problems that apply **TO YOU**:

☐ Diabetes	☐ Stroke	☐ GERD	☐ Bleeding / Blood Clots	☐ Immune System	☐ Psychological
☐ Arthritis	☐ Heart	☐ Ulcers	☐ Hepatitis / Liver	☐ Asthma / COPD	☐ Seizures / Epilepsy
☐ Kidney	☐ Thyroid	☐ Cancer	☐ High blood pressure	☐ Lung	☐ High Cholesterol

- Other: _____
- List any previous surgeries:_____

  _____
- List the medications you are currently taking:_____

  _____
- List any allergies: Medicine_____

  Food:_____

Family History

Check any problems **PAST** and **CURRENT** that apply to **FAMILY** members: (Parents / Grandparents / Siblings)

☐ Diabetes	☐ Stroke	☐ GERD	☐ Bleeding / Blood Clots	☐ Immune System	☐ Psychological
☐ Arthritis	☐ Heart	☐ Ulcers	☐ Hepatitis / Liver	☐ Asthma / COPD	☐ Seizures / Epilepsy
☐ Kidney	☐ Thyroid	☐ Cancer	☐ High blood pressure	☐ Lung	☐ High Cholesterol

- Other: _____

Social History

- Marital Status: ☐Single ☐Married ☐Divorced ☐Partner ☐Widowed • Children_____
- Current Occupation _____
- How much alcohol do you drink ? _____ / week How much do you smoke / use tobacco? _____
- Do you use recreational drugs? _____

D.O.S. _____/_____/_____ **MD/PA-C Signature:** _____

3 Please list your HEIGHT: _____ft_____in and WEIGHT:_____lbs

Mark any of the symptoms below that YOU have had RECENTLY (last 6 weeks): I have no symptoms._____

Constitutional	☐ Sore Throat	☐ Chronic cough	☐ Incontinence	☐ Bi-polar	☐ Big weight change
☐ Fever	☐ Earache		☐ Painful urination	*Skin*	*Heme/Lymphatic*
☐ Sudden Weight Loss	☐ Corrected Hearing	*G.I.*	*Musculoskeletal*	☐ Rash	☐ Easy bruise/bleed
Eyes	*Cardiovascular*	☐ Nausea/Vomiting	☐ Back/Neck pain	*Neurologic*	☐ Swollen glands
☐ Corrected vision	☐ Chest Pain	☐ Diarrhea	☐ Joint pain	☐ Headaches	*Allergic / Immune*
☐ Vision changes	☐ Palpitations	☐ Constipation	☐ Muscle pain	☐ Muscle weakness	☐ Hives
E.N.T.	☐ Varicose veins	☐ Heartburn		*Endocrine*	☐ Hay fever
☐ Runny nose	*Respiratory*	*G.U.*	*Mental Health*	☐ Excessive appetite	☐ Allergic to eggs
☐ Sinus pain	☐ Shortness of Breath	☐ Increased frequency urination	☐ Feeling depressed / Sad	☐ Cold/Heat Intolerance	

- Other: _____

_____

Your provider fills this section out:

Temp:_____ MA Initials:_____

BP: _____ Pulse:_____ O2:_____

Provider notes:

To be filled out ONLY by clinic personal:

Provider face to face time: 5+ 10+ 15+ 20+ 25+ 30+ 40+ 45+ 60+

D.O.S. _____/_____/_____ **MD/PA-C Signature:** _____