ORTHOONE
JACKSONVILLE
EXCELLENCE IN ORTHOPEDIC CARE

Today's Date: _____

Patient's Name: _____

Address: _____

City:_____State:_____ Zip Code: _____

DOB:_____ SSN:_____

Sex:____Male____Female Marital Status:____Single____Married____Divorced____Widow

Home Phone:_____ Cell Phone: _____

Email:_____

IN CASE OF EMERGENCY

Name:_____Relationship to Patient: _____

Home Phone:_____ Cell Phone:_____Work Phone: _____

INJURY INFORMATION

Type Of injury: ____Auto ____Slip & Fall ____Work_____Other **Date of Accident**: _____

If Auto:____Driver____Passenger

AUTO INSURANCE / WORKERS COMP

Insurance Name: _____

Claim Number:_____Policy Number: _____

Adjuster:_____Adjusters Phone Number:_____Ext: _____

ATTORNEY INFORMATION

Law Firm:_____Attorney Name: _____

Paralegal: _____

Phone Number:_____Fax: _____

I authorize the release of medical information necessary to process this and related insurance claims. I authorize the payment of insurance benefits to be made to: ORTHO ONE JACKSONVILLE. To whom the assignment has been made.

Patient Signature:_____ SIGN HERE **Date:** _____

PATIENT MEDICAL HISTORY

Patient's Name:_____ **Today's Date:**_____

Date of Birth: _____ **Age:** _____ **Height:**_____ **Weight:**_____

Sex :_____ **Race:**_____ **Ethnicity:**_____ **Preferred Language:**_____

Home Phone:_____ **Work Phone:**_____ **Cellular Phone:**_____

Pharmacy:_____ **Pharmacy address & phone:**_____

CHIEF COMPLAINT

**Why are you here today? _____

**What Happened? _____

Are you Right or Left Handed? _____ Date of Injury or Onset of Symptoms? _____

Is this injury due to one or more of the following: (please circle) ☐ Auto related ☐ Work related ☐ Slip and Fall

Other (please explain)_____

Were you seen in the E.R./or by another physician? _____

Are your symptoms improving/unchanged/or worsening?_____

Are you working now? _____ What is your Occupation? _____

HISTORY OF PRESENT ILLNESS

Initial symptoms:

☐ Catching ☐ Locking ☐ Weakness ☐ Numbness

☐ Initial popping sound ☐ Slipping ☐ Pain with overhead activity ☐ Tingling

☐ Giving way ☐ Stiffness ☐ Pain with reaching behind neck/back

☐ Weight bearing: ☐ with pain ☐ with no pain ☐ unable to bear weight ☐ Night Pain

Pain : ***PLEASE ANSWER THE FOLLOWING TO HELP YOU DESCRIBE YOUR PAIN***

Quality - ☐ *Aching* ☐ *Burning* ☐ *Diffuse* ☐ *Dull* ☐ *Knifelike* ☐ *Pounding*

☐ *Sharp* ☐ *Stabbing* ☐ *Tearing* ☐ *Throbbing*

Frequency of your Pain: Intermittent_____ Constant_____ Frequent_____ Infrequent_____

Severity of your pain **at this time**:(Mild--1--2--3) (Moderate--4--5--6--7) (Intense--8--9-10) (Rate pain on a scale from 1 to 10)

Severity of your pain **at its worse**:(Mild--1--2--3) (Moderate--4--5--6--7) (Intense--8--9-10) (Rate pain on a scale from 1 to 10)

Activity Limitations: Please *check* any of the following limitations that apply or write your own personal limitation.

☐ Climbing stairs ☐ In and out of chair ☐ Walking ☐ Lifting

☐ In and out of car ☐ Kneeling ☐ Bending forward ☐ Household chores

☐ Working light duty ☐ Unable to work ☐ Yard work ☐ Getting dressed

My personal limitations: _____

What makes symptoms worse?_____

What makes symptoms better?_____

Therapies tried:

☐ Braces ☐ Crutches ☐ Cold/Heat ☐ Elevation ☐ Physical Therapy ☐ Chiropractor

Medication:

☐ Anti-inflammatory ☐ Narcotics ☐ Steroids ☐ Over-the-counter ☐ Injections

Any previous medical or surgical treatment for this condition? ◯ Yes ◯ No If yes, what:_____

_____

PAST MEDICAL HISTORY

Patient's Name:_____ **Today's Date:**_____

Please list your past illnesses

_____
_____
_____
_____
_____

Please list your past injuries.

_____
_____
_____
_____
_____

CURRENT MEDICATIONS

Medication Name	Dose	Why are you taking this medication?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: (Please answer Y for yes or N/A if not applicable. **If yes,** please describe the adverse symptoms or reaction.
List medications you are allergic to:_____
_____
Environmental Allergies:_____
Food Allergies:_____
Cosmetic or personal care product Allergies:_____
Plastic Allergy:_____
Latex Allergy:_____

PAST SURGICAL HISTORY:

Surgical Procedure	Date	Name of Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILDHOOD DISEASES:
Asthma_____ Chicken Pox_____ Measles _____ Mumps_____ Rheumatic fever_____ Scarlet fever____

SOCIAL HISTORY:
Marital Status: _____Married _____Single _____Divorced _____Widowed _____Separated
Tobacco use - Current Smoker: Amount and duration _____Former Smoker ☐ Never Smoker ☐
Alcohol - **Wine** - Occasional_____ 2-3 times per week_____ Daily_____ Socially only_____
Mixed drinks or Hard Liquor - Occasional_____ 2-3 times per week_____ Daily_____ Socially only_____
Beer - Occasional_____ 2-3 times per week_____ Daily_____ Socially only_____
Ancillary aids - Glasses _____ Contacts _____ Dentures _____ Hearing aids _____
Drug use - Never used Drugs_____used Drugs in the past _____Using Drugs now Socially_____
Camping/Hunting - if yes, when & where _____
Scuba diving - if yes, state how often, how deep you dive and for how long: _____
Travel outside of the country, if so _____ where _____when

FAMILY HISTORY:
Father Status _____living ____ deceased
Illness_____
Cause of death_____; _____age at death

Mother Status _____living ____ deceased
Illness_____
Cause of death _____: _____age at death

REVIEW OF MEDICAL SYSTEMS

Patient's Name:_____ **Today's Date:**_____

General/Constitutional:

Yes	No	
◯	◯	Decreased Activity
◯	◯	Change in appetite
◯	◯	Fever
◯	◯	Chills
◯	◯	Tires easily
◯	◯	Lost Weight
◯	◯	Gained Weight

Eyes:

Yes	No	
◯	◯	Recent vision changes
◯	◯	Double Vision

Ears Nose Throat:

◯	◯	Earaches
◯	◯	Hearing loss
◯	◯	Ear pain
◯	◯	Ear Ringing
◯	◯	Dizziness
◯	◯	Congestion
◯	◯	Nose Bleeds
◯	◯	Bleeding gums
◯	◯	Full Dentures
◯	◯	Partial Upper Dentures
◯	◯	Partial Lower Dentures
◯	◯	Difficulty swallowing
◯	◯	Hoarseness
◯	◯	Sore throat

Respiratory:

Yes	No	
◯	◯	Asthma
◯	◯	Bronchitis
◯	◯	Cough
◯	◯	Shortness of Breath
◯	◯	Bronchitis
◯	◯	Coughing up blood
◯	◯	Recent Respiratory Infection
◯	◯	Sleep Apnea

GI:

Yes	No	
◯	◯	Abdominal pain
◯	◯	Nausea
◯	◯	Vomiting
◯	◯	Diarrhea
◯	◯	Heartburn
◯	◯	Indigestion

Musculoskeletal:

Yes	No	
◯	◯	Joint pain
◯	◯	Tenderness
◯	◯	Weakness
◯	◯	Swelling
◯	◯	Redness
◯	◯	Stiffness
◯	◯	Cramping
◯	◯	Loss of motion

Neurological:

Yes	No	
◯	◯	Abnormality of walk
◯	◯	Balance
◯	◯	Blackouts
◯	◯	Burning sensations
◯	◯	Confusion
◯	◯	Coordination
◯	◯	Dizziness
◯	◯	Fainting
◯	◯	Headaches
◯	◯	Lightheadedness
◯	◯	Loss of consciousness
◯	◯	Loss of sensation
◯	◯	Memory loss
◯	◯	Numbness
◯	◯	Paralysis
◯	◯	Speech difficulty
◯	◯	Tingling
◯	◯	Tremor
◯	◯	Weakness

Skin:

Yes	No	
◯	◯	Lesions
◯	◯	Itching
◯	◯	Discoloration
◯	◯	Rash
◯	◯	Ulceration

Since the incident have you experienced any of the following questions.....

Psychiatric:

Yes	No	
◯	◯	Compulsive behavior
◯	◯	Mood swings

Hematologic/lymphatic:

Yes	No	
◯	◯	Easy bruising
◯	◯	Swollen lymph node
◯	◯	History of transfusion

GU:

Yes	No	
◯	◯	Pain with urination
◯	◯	Blood in Urine
◯	◯	Abnormal Urine test
◯	◯	Frequent urination
◯	◯	Kidney stones
◯	◯	Prostate surgery

Females

Yes	No	
◯	◯	Normal Menstruation
◯	◯	Menopause
◯	◯	Ovaries removed
◯	◯	Birth control pills

Cardiac:

Yes	No	
◯	◯	Chest pain
◯	◯	Heart murmur
◯	◯	Hypertension
◯	◯	Abnormal EKG
◯	◯	Cold hands & feet
◯	◯	Palpitations
◯	◯	Abnormal stress test
◯	◯	Edema

ORTHOONE
EXCELLENCE IN ORTHOPEDIC CARE

PRIMARY CARE PHYSICIAN:

DOCTOR'S NAME: _____
FACILITY: _____
PHONE NUMBER: _____

NEUROLOGIST:

DOCTOR'S NAME: _____
FACILITY: _____
PHONE NUMBER: _____

CHIROPRACTIC DOCTOR:

DOCTOR'S NAME: _____
FACILITY: _____
PHONE NUMBER: _____
How Many Days/ Weeks/ Months of treatment? _____

Did the treatment help? _____ How Much Improvement? _____ [On a Scale 0% -100 %]

PAIN MANAGEMENT DOCTOR:

DOCTOR'S NAME: _____
FACILITY: _____
PHONE NUMBER: _____
How Many Days/ Weeks/ Months of treatment? _____
Did the treatment help? _____ How Much Improvement? _____ [On a Scale 0% -100 %]
What type of Injections/procedures have you received: (Please Circle below)

Epidural steroid injection	Selective nerve root block (SNRB)	Facet joint block
Facet Rhizotom	Sacroiliac Joint Block	Radiofrequency ablation

Other: _____