Dearborn Heights Office:
24430 Ford Rd
Dearborn Heights, MI 48127
Tel. (313) 749-0370
Fax. (313) 447-2234

Flint Office:
4800 S Saginaw St.
Suite 1625
Flint MI 48507
Tel. (810) 484-3006
Fax. (810) 213-0412

RETURNING PATIENTS NEED ONLY TO FILL OUT CHANGED OR UPDATED INFORMATION

HISTORY OF PRESENT ILLNESS (Please Print) DATE:

PATIENT'S NAME: FIRST	MIDDLE	LAST	SEX ☐ M ☐ F	AGE	DATE OF BIRTH	DOMINANT HAND ☐ LEFT ☐ RIGHT

OCCUPATION (DESCRIBE YOUR JOB DUTIES) — ACTIVE RETIRED DISABLED DATE

CHIEF COMPLAINT: — RACE

WAS THIS AN INJURY? — INJURY DATE OR BEGAN AS AN ISSUE — TYPE OF CLAIM
☐ INSURANCE CLAIM ☐ WORKER'S COMP ☐ AUTO CLAIM ☐ OTHER ____________________

HOW DID THIS INJURY OCCUR? — RATE YOUR PAIN 1-10 (10 BEING THE WORST)

WHAT MAKES THE PROBLEM WORSE? — WHAT MAKES THE PROBLEM BETTER?

WERE ANY OF THE FOLLOWING TAKEN OF THE AREA? WHEN & WHERE?
❑X-RAY__________ ❑MRI__________ ❑CT SCAN__________ ❑EMG__________ ❑MYELOGRAM__________

SYMPTOMS: ❑NUMBNESS/TINGLING ❑WEAKNESS ❑NECK PAIN ❑NIGHT PAIN
❑SWELLING ❑INSTABILITY ❑SHOOTING PAIN ❑RADIATING PAIN
❑DIFFICULTY WITH OVERHEAD ACTIVITIES ❑DIFFICULTY WALKING UP AND DOWN STAIRS

HAVE YOU TRIED:
❑PHYSICAL THERAPY ❑INJECTIONS ❑SPLINTING ❑MEDICATION(S)

DID YOU UTILIZE:
❑CRUTCHES ❑WHEELCHAIR ❑BRACE ❑CAST ❑SPLINT

REFERRING DOCTOR (NAME AND PHONE NUMBER) — FAMILY DOCTOR (NAME AND PHONE NUMBER)

HOW DID YOU HEAR ABOUT US?

ARE YOU ON DISABILITY?
☐YES ☐NO

ARE YOU IN THE PROCESS OF OBTAINING DISABILITY?
☐YES ☐NO

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY/CARRIER		
POLICY HOLDER'S NAME	POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE
CONTRACT / ID NUMBER		GROUP

SECONDARY

INSURANCE COMPANY/CARRIER		
POLICY HOLDER'S NAME	POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE
CONTRACT / ID NUMBER		GROUP

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I AUTHORIZE INSIGHT ORTHOPEDIC SPECIALISTS THE REQUEST TO RELEASE ANY OF MY MEDICAL RECORDS FROM ANY HOSPITAL OR OTHER FACILITY I HAVE BEEN TREATED. I ALSO AUTHORIZE THE FOLLOWING PEOPLE TO BE SPOKEN TO IN REGARDS TO MY MEDICAL CARE:

NAME	RELATIONSHIP	NAME	RELATIONSHIP
NAME	RELATIONSHIP	NAME	RELATIONSHIP

SIGNATURE — DATE

PLEASE FLIP OVER →

PATIENT INFORMATION

YOUR STREET ADDRESS	CITY AND STATE	ZIP CODE	SOCIAL SECURITY NO.
E-MAIL	HOME PHONE NO. ( )		CELL PHONE NO. ( )
PATIENT'S EMPLOYER (NAME & ADDRESS)			WORK PHONE NO. (INCLUDE EXT.) ( )
PERSON TO CONTACT (OTHER THAN YOUR HOME PHONE NO.)	RELATIONSHIP		PHONE NO. ( )
PHARMACY NAME	PHONE NO.	FAX NO	

MEDICAL HISTORY

(Please select all those that apply to you)

❑ **None** ❑ High Blood Pressure ❑ Diabetes ❑ High Cholesterol ❑ Stroke ❑ Blood Clot

❑ Asthma ❑ COPD ❑ Seizures ❑ Ulcers ❑ Arthritis ❑ Osteoporosis ❑ Pacemaker ❑ AFIB

❑ Heart Attack ❑ TIA (Mini Stroke) ❑ Arrhythmia ❑ Cancer ____________________ ❑ Other ____________________

ARE YOU ON BLOOD THINNERS: ❑ No ❑ Yes: Name ____________________ Why? ________________

DO YOU HAVE ANY METAL IN YOUR BODY: ❑ No ❑ Yes: Where? ____________________

Height:	
Weight:	

ALLERGIES:

ANESTHETICS	DRUG	FOOD	METAL	OTHER
❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO

SOCIAL HISTORY:

❑ YES	❑ NO	**Do you smoke cigarettes?** If yes, ______ packs per Day/Week
❑ YES	❑ NO	**Recreational Drugs?** If yes, what type & amount? ________________
❑ YES	❑ NO	**Alcohol?** If yes, ______drinks per Day/Week
❑ YES	❑ NO	**Caffeine?** If yes, ______drinks per Day/Week
❑ YES ❑ YES	❑ NO ❑ NO	**CURRENTLY ABLE TO WORK?** If **No** is it due to this problem? Last time you worked ______________

Do you travel? ❑ Local ❑ State ❑ Nation ❑ International

Marital Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced

MEDICATION(S): *(Please list your current medications)* **Circle any medications you feel you have become addicted to.**

Name	Dosage	Name	Dosage	Name	Dosage	Name	Dosage

SURGICAL/HOSPITALIZATION HISTORY: *(Please list your surgeries/hospitalizations with approximate dates)*

FAMILY HISTORY: *(Serious illness for example bleeding, blood clot, heart attack)*

FATHER	ALIVE / DECEASED	
MOTHER	ALIVE / DECEASED	
PATERNAL GRANDFATHER	ALIVE / DECEASED	
PATERNAL GRANDMOTHER	ALIVE / DECEASED	
MATERNAL GRANDFATHER	ALIVE / DECEASED	
MATERNAL GRANDMOTHER	ALIVE / DECEASED	