NEW PATIENT QUESTIONAIRE

RETURNING PATIENTS NEED ONLY TO FULL OUT CHANGED OR UPDATED INFORMATION

PATIENT INFORMATION (Please Print) DATE:

PATIENT'S NAME FIRST MIDDLE LAST	SEX ☐ M ☐ F	RACE	DATE OF BIRTH	SOCIAL SECURITY NO.

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO. ( )

E-MAIL	CELL PHONE NO. ( )

PATIENT'S EMPLOYER (NAME & ADDRESS)	WORK PHONE NO. (INCLUDE EXT.) ( )

OCCUPATION (DESCRIBE YOUR JOB DUTIES)	ACTIVE RETIRED DISABLED DATE

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

PERSON TO CONTACT (OTHER THAN YOUR HOME PHONE NO.)	RELATIONSHIP	PHONE NO. ( )

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

HOW DID YOU HEAR ABOUT US?	PHARMACY NAME	PHONE 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

INJURY INFORMATION

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

WERE ANY OF THE FOLLOWING TAKEN OF THE ISSUE ☐ X-RAYS ☐ MRI ☐ CT SCAN ☐ EMG ☐ MYELOGRAM	WHERE WERE THEY TAKEN	DATE TAKEN

EXPLAIN HOW INJURY OR PROBLEM OCCURRED	LAWSUIT FILED ☐ YES ☐ NO

NAME OF CARRIER		

CARRIER ADDRESS	CITY AND STATE	ZIP CODE

POLICY HOLDER NAME	CLAIM NO.	NAME OF CLAIM REPRESENTATIVE/ATTORNEY	PHONE # ( )

I AUTHORIZE INSIGHT ORTHOPEDICAL SPECIALIST'S THE REQUSET 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

CHIEF COMPLAINT: *(Please describe why you are here i.e. "My right knee hurts")*

_____

_____

ON A SCALE OF 1-10, PLEASE RATE YOUR PAIN WITH 10 BEING THE MOST SEVERE: _____

WHAT MAKES THE PROBLEM WORSE *(i.e. walking or squatting):* _____

WHAT MAKES THE PROBLEM BETTER *(i.e. pain med, rest, ice, heat):* _____

WHEN DID YOU START HAVING THIS PROBLEM: *(Date of injury or duration in weeks/months):* _____

HAVE YOU TRIED: ❑ Physical Therapy ❑ Injections ❑ Splinting ❑ Medication(s)

DO YOU UTILIZE: ❑ Crutches ❑ Wheelchair ❑ Brace ❑ Cast ❑ Splint

PAST MEDICAL: *(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
❑ Diabetes ❑ Cancer _____ ❑ Other _____

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

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

DOMINATE HAND: ❑ Left ❑ Right

CURRENTLY ABLE TO WORK? ❑ Yes ❑ No, is it due to this problem? ❑ Yes ❑ No Last time you worked _____

Height:
Weight:

ALLERGIES:

DRUG	ANESTHETICS	FOOD	OTHER
❑ 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
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.**

PAST SURGICAL HISTORY: *(Please list your surgeries 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	