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

INSIGHT
ORTHOPEDIC SPECIALISTS

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

Dear Patient: You will be asked questions regarding race and ethnicity during the registration process. We do not ask these questions to limit or deny you services. We ask these questions to give you better care. By gathering this data, we can better prevent, test for, and treat the diseases or health conditions that may affect you. You may refuse to provide us with this information. You will only be asked these questions once.

RACE ❑Asian ❑Black, African or African American ❑American Indian or Alaskan Native ❑White ❑Native Hawaiian or other Pacific Islander ❑Other Races ❑Two or more races ❑Unknown

ETHNICITY ❑ Hispanic or Latino ❑ Neither

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

Check ALL conditions that apply to you ❑**NONE**

High Blood Pressure
- ☐ Essential Primary Hypertension (I10)

Blood Clots/Embolism
- ☐ Personal History of other venous thrombosis and embolism (Z86.718)

Diabetes
- ☐ Type 2 diabetes with diabetic neuropathy (E11.40)
- ☐ Type 2 diabetes with unspecified complications (E11.8)
- ☐ Type 2 diabetes unspecified (E11.9)

COPD
- ☐ Chronic obstructive pulmonary disease (J44.9)

High Cholesterol
- ☐ Pure Hypercholesterolemia, Unspecified (e78.00)

Chronic Bronchitis
- ☐ Simple chronic bronchitis (J41.0)

Asthma
- ☐ Unspecified asthma (J45.909)

Arthritis
- ☐ Unsepcified Osteoarthritis (M19.90)

Osteoporosis
- ☐ Age-related osteoporosis without current pathological fracture (M81.0)

Pacemaker
- ☐ Presence of cardiac pacemaker (Z95.0)

Heart Attack
- ☐ Old Myocardial Infarction (I25.2)

TIA (Mini Stroke)
- ☐ Transient Cerebral Ischemic Attack, Unspecified

Ulcers
- ☐ Personal History of Diseases of the skin and subcutaneous tissue (Z87.2)

Emphysema
- ☐ Other emphysema (J43.8)

Rheumatoid Arthritis
- ☐ Rheumatoid arthritis with rheumatoid factor (M05.9)
- ☐ Rheumatoid myopathy with rheumatoid arthritis of unspecified site (M05.40)

Hepatitis C
- ☐ Chronic viral hepatitis C (B18.2)

Cirrhosis of the liver
- ☐ Alcoholic cirrhosis of liver without ascites(K70.30)
- ☐ with ascites (K70.31)
- ☐ Other chirrhosis of liver (K74.89)

Renal/Kidney disease
- ☐ End stage renal disease (N18.6)
- ☐ Chronic kidney disease stage 1 (N18.1)
- ☐ Chronic kidney disease stage 2 (N18.2)
- ☐ Chronic kidney disease stage 3 (N18.3)
- ☐ Chronic kidney disease stage 4 (N18.4)
- ☐ Chronic kidney disease stage 5 (N18.5)

Alzheimers/Dementia
- ☐ Alzheimer's disease with early onset (G30.0)
- ☐ Alzheimer's disease with late onset (G30.1)
- ☐ Alzheimer's unspecified (G30.9)
- ☐ Unspecified dementia without behavioral disturbance (F03.90)
- ☐ Unspecified dementia with behavior disturbance (F03.91)

Depression/Bipolar Disorder
- ☐ Major depressive disorder, recurrent, moderate (F33.1)
- ☐ Bipolar II disorder (F31.81)
- ☐ Other bipolar disorder (F31.89)

Schizophrenia
- ☐ Paranoid schizophrenia unspecified (F20.0)
- ☐ Unspecified schizophrenia (F20.3)

Multiple Sclerosis
- ☐ Multiple sclerosis (G35)

Epilepsy/Seizures
- ☐ Other epilepsy not intractable (G40.802)
- ☐ Seizures (G40.89)

Heart Failure/Atrial Fibrillation/Unstable Angina
- ☐ Heart failure unspecified (I50.9)
- ☐ Unspecified atrial fibrillation and atrial flutter (I48.9)
- ☐ Unstable angina (I20.0)

Stroke
- ☐ Other cerebral infarction (I63.8)
- ☐ Cerebral infarction unspecified (I63.9)

Cancer: _____
What type? _____

Others: _____

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 ☐ NO ☐ YES ☐ 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	