

Patient's Name: _____ **Sex:** Male Female **Age:** _____ **Date:** _____
Date of Birth: _____

Height: _____ **Weight:** _____
Dominant Hand: Left Right
Rate Your Pain : 1-10 (10 being the worst) _____

ALLERGIES: NONE

ANESTHETICS	DRUG	FOOD	METAL	OTHER
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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 **CURRENTLY ABLE TO WORK?**
 YES NO **If No is it due to this problem?** Last time you worked _____

YES NO **ARE YOU PREGNANT?**

Do you travel? Local State Nation International

Marital Status: Single Married Widowed Divorced

REFERRING DOCTOR (Name and Phone Number) _____ **FAMILY DOCTOR (Name and Phone Number)** _____

HOW DID YOU HEAR ABOUT US?

MEDICATION(S): NONE (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: NONE (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

NOTICE OF PRIVACY PRACTICES
 Our office's Notice of Privacy Practice explains your rights and our policies regarding the protection of your personal health information. It is always kept here posted at the front desk. We are required by federal law to show it to you and get your signature to acknowledge that we have done so. If you would like, you may read it before you sign this or we can give you a copy to take home. Please sign below.

ACKNOWLEDGMENT OF RECEIPT OF OFFICE PRIVACY POLICY AND FINANCIAL POLICY
 I acknowledge that Insight Orthopedic Specialists, Insight Neurosurgery, and/or Insight Comprehensive Therapy (hereby referred to as "Insight") "Notice of Privacy Practices" and "Financial Policy" has been provided to me. I understand that I have the right to review Insight's Notice of Privacy Practices and the Financial Policy prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations with Insight. It describes my rights as they concern the limited use of health information-including my demographic information collected from me and created or received by my physician. The Notice of Privacy Practices for Insight is also provided on request at the main administration desk of the facility. Insight reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a copy the revised Notice of Privacy Practices by calling the facility and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment. I also read and agree to the policies of the Financial Policy by signing below.

Signature of Patient or Personal Representative _____ Date _____

Name of Patient or Personal Representative _____ Description of Personal Representative's Authority _____

PLEASE FLIP OVER 

Authorization to Treat:

I authorize my provider to proceed with any care plan that is discussed and that I have consented to. I also authorize my provider to proceed with any procedure that I agree to in the office including but not limited to injections, aspirations, and mass excisions. I understand that I have discussed the risks and benefits with my physician to my satisfaction.

Signature of Patient/Legal Guardian: _____ Date: _____

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

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 chirrrosis of liver (K74.69)

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? _____

HISTORY OF PRESENT ILLNESS

OCCUPATION (DESCRIBE YOUR JOB DUTIES)

ACTIVE RETIRED DISABLED DATE

CHIEF COMPLAINT:

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

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?

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

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

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.		

PLEASE FLIP OVER 

Review of Symptoms (check if applicable)

General

- Weakness
- Tiredness
- Excess Appetite
- Weight Loss
- Chills
- Fever
- Difficulty Sleeping

Cardiovascular

- Chest Pain or Tightness
- Need to sit up to breathe
- Heart Racing
- Irregular Heartbeat
- Heart Murmur
- Swelling of the legs
- Varicose Veins
- Leg Pain at rest
- Leg Pain with exertion

Respiratory/Pulmonary

- Wheezing
- Shortness of Breath
- Bloody Sputum
- Pain with Breathing
- Gag, choke or cough during sleep
- Snore
- Stop breathing during sleep
- Excessive daytime sleepiness
- Wake up unrefreshed

Musculoskeletal

- Muscle pain
- Neck Pain
- Back Pain
- Arm Pain
- Pain down your legs
- Painful or stiff joints
- Redness of any joints

Neurologic - Psychiatric

- Seizures
- Headaches
- Blackouts
- Dizziness
- Double Vision
- Weakness of Limbs
- Loss of Balance
- Loss of Sensation
- Loss of Coordination
- Speech Problems
- Depression
- Problems with Memory
- Problems with Thinking

Male Reproductive

- Lump in testicles
- Discharge from penis
- Decreased Sex-Drive
- Erection Problems

Female Reproductive

- Decreased Sex-Drive
- Unusual Vaginal Bleeding
- Pregnancy
- Hormone Therapy

HEENT

- Decreased Ability to See
- Blurred Vision
- Pain in Eyes
- Difficulty Hearing
- Ringing in Ears
- Discharge from Ears
- Frequent nasal discharge

Gastrointestinal

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Heartburn
- Abdominal Pain
- Bright Red Blood in stools
- Black stools
- Change in bowel habits

Urinary

- Difficulty with Urination
- Pain with urination
- Urinary Tract Infection
- Loss of Bladder Control
- Frequent Urination

Endocrine

- Goiter
- Heat Intolerance
- Cold Intolerance
- Increased Thirst
- Change in Voice
- Change in foot/hand size
- Change in breast size

Skin

- Change in mole
- Breast lumps
- Itching
- Rash
- Redness or Infection

Hematologic

- Easy Bruising
- Prolonged Bleeding