



Office Use Only

Chart # _____

Physician: _____

Receptionist: _____

Date: _____ Patient Name: _____

Current Injury / Complaint

Are you here today as a result of an accident or injury? YES NO

If yes, give date: _____

What is the problem you are here for today? Describe symptoms: (Example: swelling, pain left leg, etc.)

LEFT RIGHT _____

How have you treated the problem? _____

Has the problem: IMPROVED WORSENERD

Who else has treated you for this problem? _____

For this problem, have you had:

CT SCAN _____

MRI SCAN _____

X-RAYS _____

OTHER _____

DR. _____ M.D. Podiatrist Chiropractor

Sports & General History

Were you injured during athletic participation? YES NO

Please Name: (Circle)

School / Club _____

Sport / Activity _____

Coach /Trainer _____

May we send your organization, coach or trainer a report of this visit? YES NO

Who referred you to OrthoWest?

M.D. COACH TRAINER FRIEND RELATIVE OTHER _____

FIRST / LAST NAME

ADDRESS

May we send your physician, coach, or trainer a report of this visit? YES NO

Name of physician treating your general health:

FIRST / LAST NAME

ADDRESS

May we send him/her a report of this visit? YES NO

I authorize release of my medical records in accordance with the specifications listed above. I understand written notification is necessary to cancel this request.

SIGNATURE OF PATIENT: _____ DATE: _____

(If signed by person other than patient, state relationship and authority to do so.)

Date: _____ Chart # _____

Past History / Review of Systems

Are you allergic to any medications or x-ray dyes? YES NO Please list the medications & your reactions:

I have been treated or am currently being treated for problems associated with:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Other Bone & Joint | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Hip problems | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Colon / Rectal Disease |
| <input type="checkbox"/> Wrist/Hand | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Ankle Problems | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> Elbow Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Knee Problems | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Other_____ |

List the dates and types of surgeries you have had: _____

List all the medications that you take: _____

Rate your general health: EXCELLENT GOOD FAIR POOR

Social History

Occupation - what kind of work do you do? _____

How many hours per week do you work? _____

Do you exercise regularly? YES, _____TIMES PER WEEK NO

Type of exercise: _____

Do you smoke? YES, _____PACKS PER DAY FOR_____YEARS NO

How many alcoholic beverages do you consume per week? 0 1-3 4-12 13+

Do you ever use non-prescription, mind altering drugs? (Ex: Marijuana) YES NO

Do you ever use performance enhancing drugs? NO YES, PLEASE LIST: _____

Family History

My family (parents, siblings) has a history of:

- | | | | |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychological Problems | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> None |
| <input type="checkbox"/> Colon / Rectal Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Cancer | <input type="checkbox"/> Neck / Spine Problems | |

Legal Issues

Is this a worker's compensation case? NO YES

Is there any other legal action pending? NO YES

Do you have an attorney assisting you? NO YES, WHOM? _____
