Northwest Orthopedic Surgery, S.C. & Northwest Rehabilitation

Patient Name: _____ **Date:** _____

If you are not the patient: Guardian name: _____

Relationship to Patient: _____

Height: ____**Ft** _____**In** **Weight:** _____**lbs** **Age:** _____ **Birth Date:** _____

Dominant Hand: ☐ **Right** ☐ **Left** **Shoe Size:** _____

Primary Care Physician: _____

Specialists: _____

History of Present Problem

Chief Complaint: (Why are you seeing the doctor today?)

_____

_____

How long have you had this problem? _____

What started the problem? _____

	Yes	No	When?
Has the problem become worse?	☐	☐	_____
Is this problem the result of a car accident?	☐	☐	_____
Is this problem the result of a work accident?	☐	☐	_____

Have you been treated previously by another physician for this condition? ☐ Yes ☐ No

Please give name of physician and date of last visit (including physicians in this practice)

_____

_____

Is this condition considered Pre-Existing by your current insurance carrier? ☐ Yes ☐ No

Prior tests done to evaluate your condition: ☐ **No Prior Tests**

Test	Date	Area Tested	Facility
☐ Plain X-rays	_____	_____	_____
☐ MRI	_____	_____	_____
☐ CAT Scan	_____	_____	_____
☐ Arthrogram	_____	_____	_____
☐ Myelogram	_____	_____	_____
☐ Bone Scan	_____	_____	_____
☐ EMG	_____	_____	_____
☐ _____	_____	_____	_____

Prior treatments for your chief complaint have included: ☐ **No Prior Treatments**

☐ Anti-Inflammatory Medication ☐ Pain Medication ☐ Steroid Injection

Physical Therapy: ☐ Exercise ☐ Massage ☐ Ultrasound ☐ Traction

How many physical therapy treatment sessions this calendar year? _____

☐ Other: (please list) _____

Rate your pain severity using the following scale: (please circle a number)

1	2	3	4	5	6	7	8	9	10
None		Slight		Moderate		Severe		Extreme	

Describe your pain: ☐ **None apply**

☐ Sharp ☐ Dull ☐ Shooting ☐ Aching ☐ Burning ☐ Throbbing
☐ Continuous ☐ Intermittent Other: _____

What is your chief complaint made worse by? ☐ **None apply**

☐ Activity ☐ Work ☐ Standing ☐ Sitting ☐ Walking ☐ Laying down ☐ Stairs
☐ Movement (body part: _____) ☐ Touch (body part: _____)

Does anything make your chief complaint better? ☐ Yes ☐ No

If yes, please explain: _____

Signs and Symptoms associated with your chief complaint: ☐ **None apply**

	Location		**Location**
☐ Pain	_____	☐ Numbness	_____
☐ Swelling	_____	☐ Tingling	_____
☐ Warmth	_____	☐ Muscle Atrophy	_____
☐ Redness	_____	☐ Muscle Spasm	_____
☐ Skin Changes	_____	☐ Muscle Twitching	_____
☐ Bruising	_____	☐ Loss of Movement	_____
☐ Drainage	_____	☐ Weakness	_____
☐ Other:			

Review of Symptoms: (please check all that **currently** apply) ☐ **None apply**

☐ Fever or chills	☐ Anemia	☐ Thyroid Problems
☐ Recent weight change	☐ Heart or chest pain	☐ Change in urine function
☐ Very low energy	☐ Chest pain with breath	☐ Difficulty urinating
☐ Trouble with vision	☐ Abnormal heart beat	☐ Frequent urination
☐ Itchy eyes	☐ Shortness of breath	☐ Blood in urine
☐ Sinus infections	☐ Swollen ankles or feet	☐ Leaking urine
☐ Dizziness	☐ Poor circulation	☐ Burning on urination
☐ Frequent headaches	☐ Persistent cough	☐ Swollen or stiff joints
☐ Loss of hearing	☐ Wheezing	☐ Red or warm joints
☐ Ear pain or drainage	☐ Rashes/Hives	☐ Broken bones
☐ Ringing in ears	☐ Nausea or vomiting	☐ Neck or back pain
☐ Frequent nose bleeds	☐ Diarrhea or constipation	☐ Leg or arm pain
☐ Bad snoring	☐ Change in bowel function	☐ Blackouts or seizures
☐ Sore throat	☐ Stomach pain	☐ Loss of memory
☐ Change in voice	☐ Blood in stool	☐ Weakness of arms or legs
☐ Difficulty swallowing	☐ Dark or tar looking stool	☐ Poor balance
☐ Easy bruising or bleeding	☐ Ulcers	☐ Nervous exhaustion
☐ Swollen lymph glands	☐ Frequent infections	☐ Depression or anxiety
☐ Gum or tooth problems	☐ New Moles or skin lesions	☐ Other:

Signature of Patient (or Guardian if minor)

Northwest Orthopedic Surgery, S.C. & Northwest Rehabilitation

Medical History

Patient Name: _____ **Date:** _____

Allergies to Medications: (please list all) ☐ **No Known Allergies**

Medication	Rash	Wheezing	Swelling	Upset stomach	Shock	Other effect
_____	☐	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	☐	_____

Other Allergies: _____

Medications you take: (please list all) ☐ **None**

Medication	Dosage and Frequency	Reason For Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Herbal Supplements you take: _____

Medical History: (please check all that apply) ☐ **None apply**

☐ Heart attack	☐ Osteoporosis	☐ Gout	☐ Phlebitis
☐ Heart failure	☐ Pneumonia	☐ Stomach ulcers	☐ Blood clots in legs
☐ Heart murmur	☐ Asthma	☐ Kidney stones	☐ Blood clots in lungs
☐ High blood pressure	☐ Tuberculosis	☐ Kidney failure	☐ Bleeding disorders
☐ Stroke	☐ Emphysema	☐ Transplants	☐ Scarring tendency
☐ Diabetes	☐ Lung disease	☐ Alcohol dependence	☐ Sickle cell disease
☐ High cholesterol	☐ Blood vessel disease	☐ HIV positive/AIDS	☐ Peripheral neuropathy
☐ Rheumatoid arthritis	☐ Osteoarthritis	☐ Hepatitis	☐ Peripheral arterial disease
☐ Liver trouble	☐ Mental Illness	☐ Hyperthyroidism	☐ Peripheral vascular disease
☐ Lupus	☐ Sleep apnea	☐ Hypothyroidism	☐ Coronary artery disease
☐ GERD	☐ ADHD/ADD	☐ Hyperlipidemia	☐ Herniated disc
☐ Cancer: _____	☐ Other: _____		☐ Spinal stenosis

Surgical History: ☐ **None**

Operation	Date or Approx. Age
_____	_____
_____	_____
_____	_____
_____	_____

History of anesthesia problems: _____ ☐ **None**

Surgical Complications: _____ ☐ **None**

Other Hospitalizations: (not for surgery) ☐ **None**

Reason	**Date or Approx. Age**
_____	_____
_____	_____
_____	_____

Other Major Illness or Injury: ☐ **None**

Description	**Date or Approx. Age**
_____	_____
_____	_____
_____	_____

Family History: (check all that apply) ☐ **None apply**

Condition	**Which Family Member**	**Condition**	**Which Family Member**
☐ Heart disease	_____	☐ Scoliosis	_____
☐ Stroke	_____	☐ Spine problems	_____
☐ High blood pressure	_____	☐ Kidney failure	_____
☐ Diabetes	_____	☐ Mental illness	_____
☐ Osteoporosis	_____	☐ Bleeding disorders	_____
☐ Rheumatoid arthritis	_____	☐ Anemia	_____
☐ Osteoarthritis	_____	☐ Alcohol dependence	_____
☐ Lupus	_____	☐ Cancer of: _____	_____
☐ Sickle Cell	_____	☐ Other: (list)	_____

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Do you have children? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Describe the type of work you do: _____

Are you or could you possibly be pregnant? – ***Women only***

☐ Yes ☐ No

Risk Factors – ***Patients 13 years old and over***

Do you smoke or use tobacco? ☐ Every day ☐ Some days ☐ Former ☐ Never

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? _____

Do you exercise regularly? ☐ Yes ☐ No How often? _____

What is your primary exercise activity? _____

How is your seatbelt usage? ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

Birth History – ***Pediatric patients 12 years old and younger***

Prematurity: ☐ Yes ☐ No How early? _____

Breech: ☐ Yes ☐ No

Difficult Labor: ☐ Yes ☐ No

Difficult Pregnancy: ☐ Yes ☐ No

Birth Weight: _____lbs. _____oz.

_____

Signature of Patient (or Guardian if minor)

Northwest Orthopedic Surgery, S.C.
DBA: Northwest Rehabilitation
RAM Orthopedics

Receipt of Notice of Privacy Practices and Consent for Use and Disclosure of Protected Health Information

WITH MY CONSENT, Northwest Orthopedic Surgery, S.C., Northwest Rehabilitation and RAM Orthopedics may use and disclose protected health information (PHI) about me to carry out treatment, payment and other healthcare operations (TPO). A detailed description of uses and disclosures of PHI is provided in the Notice of Privacy Practices for Northwest Orthopedic Surgery, S.C., Northwest Rehabilitation and RAM Orthopedics. The Notice is posted in front of the office and copies are available at the front desk and at nworthopedic.com.

I HEREBY ACKNOWLEDGE RECEIPT of the Notice of Privacy Practices. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. Northwest Orthopedic Surgery, S.C., Northwest Rehabilitation and RAM Orthopedics reserve the right to revise the privacy practices described in the Notice and a revised copy of the Notice will be provided to me or made available at my next visit.

WITH MY CONSENT, Northwest Orthopedic Surgery, S.C., and/or Northwest Rehabilitation and/or RAM Orthopedics my call my home or other designated location and leave a message on voice mail in reference to any items that assist the practice to carry out TPO, such as appointment reminders, insurance related questions or items, any collection efforts and any call pertaining to my clinical care, including test results among others.

LEAVE MESSAGE WITH: _____

HOME PHONE: _____ CELL PHONE: _____

ALTERNATIVE PHONE: _____

WITH MY CONSENT, Northwest Orthopedic Surgery, S.C., and/or Northwest Rehabilitation and/or RAM Orthopedics may send mail to my home address or other designated location any items that assist the practice to carry out TPO.

WITH MY CONSENT, Northwest Orthopedic Surgery, S.C., and/or Northwest Rehabilitation and/or RAM Orthopedics may fax information that assists the practice to carry out TPO. This may include prescription requests to a pharmacy, progress notes to an insurance carrier, medical notes to a requesting physician who is involved in your healthcare or another healthcare professional, such as a therapist, athletic trainer, gym teacher and school nurse.

WITH MY CONSENT, Northwest Orthopedic Surgery, S.C., and/or Northwest Rehabilitation and/or RAM Orthopedics may electronically request and use my prescription medication history from my pharmacy benefit administrator for the purpose of continued treatment.

I UNDERSTAND THAT I HAVE THE RIGHT to request Northwest Orthopedic Surgery, S.C., and/or Northwest Rehabilitation and/or RAM Orthopedics to restrict how it uses or discloses my PHI to carry out TPO, however, I further understand that Northwest Orthopedic Surgery, S.C., and/or Northwest Rehabilitation and/or RAM Orthopedics is not required to agree to my requested restrictions. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. (Please list restrictions, if any, on reverse side.)

Patient Name: _____

Signed: _____ **Date:** _____

If you are not the patient, please specify your relationship: _____

For Office Use Only
We attempted to obtain written acknowledgement of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ Other (specify)