



FOOT • ANKLE • HAND • PAIN • SHOULDER • SPINE

Patient Registration Form

Name: _____

Date: MM / DD / YYYY

PATIENT INFORMATION	Last Name		First	MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Birth Date MM / DD / YYYY		Age	SSN - -	Drivers License
	Address		City	State	Zip
	Home Phone # () -		Work # () -	Cell # () -	
	Email			Preferred Method of Contact	
	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner				
	Spouse's Name			Phone # () -	
	Emergency Contact Name			Phone # () -	

INSURANCE	Primary Insurance		Policy #	Type of Network	Group #
	Address		City	State	Zip
	Insured's Name			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Insured's Employer			Phone # () -	
	Birth Date MM / DD / YYYY		SSN - -	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
	Insurance Address		City	State	Zip
	Person Responsible for Payment		Relationship to Patient	Phone # () -	
	Address		City	State	Zip

REFERRED BY	Physician	Magazine/Newspaper	Company
	Friend	Health Fair/Community Event	Other

PHARMACY	Pharmacy Name		Phone # () -	
	Address		City	State

PRIMARY CARE	Primary Care Physician Name		Phone # () -	
	Address		City	State



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Patient Pain Form

Name: _____

Date: MM / DD / YYYY

TODAY'S VISIT	What is the reason for your visit today?
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LOCATION OF PAIN	Ankle	<input type="checkbox"/> L <input type="checkbox"/> R	Calf	<input type="checkbox"/> L <input type="checkbox"/> R	Cervical Spine	<input type="checkbox"/> L <input type="checkbox"/> R	Chest/Sternum	<input type="checkbox"/> L <input type="checkbox"/> R
	Coccyx	<input type="checkbox"/> L <input type="checkbox"/> R	Elbow	<input type="checkbox"/> L <input type="checkbox"/> R	Finger	<input type="checkbox"/> L <input type="checkbox"/> R	Forearm	<input type="checkbox"/> L <input type="checkbox"/> R
	Foot	<input type="checkbox"/> L <input type="checkbox"/> R	Hand	<input type="checkbox"/> L <input type="checkbox"/> R	Hip	<input type="checkbox"/> L <input type="checkbox"/> R	Knee	<input type="checkbox"/> L <input type="checkbox"/> R
	Lower Back	<input type="checkbox"/> L <input type="checkbox"/> R	Lower Leg	<input type="checkbox"/> L <input type="checkbox"/> R	Ribs	<input type="checkbox"/> L <input type="checkbox"/> R	Sacrum	<input type="checkbox"/> L <input type="checkbox"/> R
	Shoulder	<input type="checkbox"/> L <input type="checkbox"/> R	Thigh	<input type="checkbox"/> L <input type="checkbox"/> R	Toes	<input type="checkbox"/> L <input type="checkbox"/> R	Upper Arm	<input type="checkbox"/> L <input type="checkbox"/> R
	Upper Back	<input type="checkbox"/> L <input type="checkbox"/> R	Wrist	<input type="checkbox"/> L <input type="checkbox"/> R	Other:	_____		<input type="checkbox"/> L <input type="checkbox"/> R
	<input type="checkbox"/> Bilateral (Both Sides) <input type="checkbox"/> Anterior (Front) <input type="checkbox"/> Posterior (Back) <input type="checkbox"/> Medial (Inner) <input type="checkbox"/> Lateral (Outer)							

TYPE	<input type="checkbox"/> Pain	<input type="checkbox"/> Stiffness
	<input type="checkbox"/> Fracture	<input type="checkbox"/> Injection
	<input type="checkbox"/> Post-Operative	<input type="checkbox"/> Follow-up

SEVERITY	<input type="checkbox"/> No Pain	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe							
	Pain Level(circle one):										
	NONE									EXTREME	
	0	1	2	3	4	5	6	7	8	9	10

DURATION	Date of Onset: _____
	_____ Days _____ Weeks
	_____ Months _____ Years

TIMING	<input type="checkbox"/> Cannot Identify	<input type="checkbox"/> Acute
	<input type="checkbox"/> Chronic	<input type="checkbox"/> Abrupt
	<input type="checkbox"/> Gradual	<input type="checkbox"/> Morning
	<input type="checkbox"/> Daytime	<input type="checkbox"/> Nighttime
	<input type="checkbox"/> Recurrent	<input type="checkbox"/> Rare
	<input type="checkbox"/> Occasional	<input type="checkbox"/> Continuous
	<input type="checkbox"/> Intermittent Episodes Lasting: _____	

QUALITY	<input type="checkbox"/> Aching	<input type="checkbox"/> Burning
	<input type="checkbox"/> Gnawing	<input type="checkbox"/> Stabbing
	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Sharp
	<input type="checkbox"/> Dull	<input type="checkbox"/> Superficial
	<input type="checkbox"/> Deep	<input type="checkbox"/> Occasional
	<input type="checkbox"/> Frequent	<input type="checkbox"/> Constant
	<input type="checkbox"/> Worsening	<input type="checkbox"/> Improving
<input type="checkbox"/> No Change		

CONTEXT	<input type="checkbox"/> Cannot Identify	<input type="checkbox"/> Fall
	<input type="checkbox"/> Bending	<input type="checkbox"/> Lifting
	<input type="checkbox"/> Twisting	<input type="checkbox"/> Sports Injury
	<input type="checkbox"/> Work Injury	<input type="checkbox"/> Car Accident
	<input type="checkbox"/> Assault	<input type="checkbox"/> Overuse
	<input type="checkbox"/> Laceration	<input type="checkbox"/> Heard a Pop
	<input type="checkbox"/> Other: _____	

ALLEVIATING FACTORS	<input type="checkbox"/> Nothing Helps	<input type="checkbox"/> Ice
	<input type="checkbox"/> Rest	<input type="checkbox"/> Elevation
	<input type="checkbox"/> Exercise	<input type="checkbox"/> Stretching
	<input type="checkbox"/> PT/OT	<input type="checkbox"/> NSAIDs
	<input type="checkbox"/> Orthotics	<input type="checkbox"/> Brace
	<input type="checkbox"/> Previous Surgery	<input type="checkbox"/> Sling
	<input type="checkbox"/> Limited Weight-bearing	
	<input type="checkbox"/> Chiropractic Care	<input type="checkbox"/> Narcotics
	<input type="checkbox"/> Epidural Steroid Injection	
	<input type="checkbox"/> Over-the-counter Medication	
	<input type="checkbox"/> Cortisone Injection	
	<input type="checkbox"/> Viscosupplementation Injection	
	<input type="checkbox"/> Other: _____	

AGGRAVATING FACTORS	<input type="checkbox"/> Cannot Identify	<input type="checkbox"/> Lifting
	<input type="checkbox"/> Carrying	<input type="checkbox"/> Twisting
	<input type="checkbox"/> Pushing/Pulling	<input type="checkbox"/> Gripping
	<input type="checkbox"/> Grasping	<input type="checkbox"/> Squeezing
	<input type="checkbox"/> Throwing	<input type="checkbox"/> Range of Motion
	<input type="checkbox"/> Weight-bearing	<input type="checkbox"/> Exercise
	<input type="checkbox"/> Previous Surgery	<input type="checkbox"/> Computer Use
	<input type="checkbox"/> Changing Clothes	<input type="checkbox"/> Getting Out of Bed
	<input type="checkbox"/> Going from Sit to Stand	
	<input type="checkbox"/> Morning	<input type="checkbox"/> Daytime
	<input type="checkbox"/> Nighttime	<input type="checkbox"/> Cold Weather
	<input type="checkbox"/> Damp Weather	<input type="checkbox"/> Driving
	<input type="checkbox"/> Other: _____	

PRIOR RELATED INCIDENCES	Prior Related Surgery <input type="checkbox"/> None <input type="checkbox"/> Yes	Procedure Type	Procedure Date MM / DD / YYYY
	Prior Imaging (Past 3 Months) <input type="checkbox"/> None <input type="checkbox"/> Yes	Imaging Type <input type="checkbox"/> X-Ray <input type="checkbox"/> MRI <input type="checkbox"/> Other: _____	Imaging Date MM / DD / YYYY
	Previous Injections <input type="checkbox"/> None <input type="checkbox"/> Yes	Injection Type	Injection Date MM / DD / YYYY
	<input type="checkbox"/> Injections Did Not Help <input type="checkbox"/> Injections Helped a Little <input type="checkbox"/> Injections Helped Temporarily <input type="checkbox"/> Injections Helped Significantly		
	Previous Therapy <input type="checkbox"/> None <input type="checkbox"/> Yes	Therapy Type	Therapy Date MM / DD / YYYY
	<input type="checkbox"/> Therapy Did Not Help <input type="checkbox"/> Therapy Helped a Little <input type="checkbox"/> Therapy Helped Temporarily <input type="checkbox"/> Therapy Helped Significantly		



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Patient Symptoms & History Form

Name: _____

Date: / /

Please review and mark **ALL** items that have applied to you **within the last month** (including today)

REVIEW OF SYMPTOMS

- General: Fever Chills Night Sweats Unexpected Weight Loss or Gain Fatigue Loss of Appetite
 - Skin: Rash Skin Lesions Abnormal Mole Jaundice Itching
 - Eyes: Eye Pain Double Vision Severe Redness
 - Ears: Ear Pain Difficulty Hearing Ringing in Ears Dizziness
 - Nose: Runny Nose Nasal Congestion Frequent Nose Bleeds Nasal/Sinus Pressure
 - Mouth/Throat: Sore Throat Difficulty Swallowing Bleeding Gums Sores in Mouth Tooth Pain Hoarseness
 - Chest/Heart: Chest Pain Racing/Pounding Heart Palpitations Shortness of Breath when Lying Down
 Lower Leg Swelling Fainting Calf Pain with Walking
 - Neck: Pain Swelling
 - Respiratory: Shortness of Breath Cough Wheezing Coughing up Blood
 - Stomach: Nausea/Vomiting Heartburn Abdominal Pain Vomiting Blood
 - Bowels: Diarrhea Constipation Black/Tarry/Bloody Stools Unusual Change in Stool Size/Shape/Color
 - Urinary Tract: Blood in Urine Increased Urination Difficulty Urinating Pain when Urinating Waking to Urinate
 - Musculoskeletal: Joint Pain Muscle Weakness Back Pain Swelling in Extremities Limited Range of Motion in Joints
 - Neurological: Seizures Problems with Coordination Memory/Sensory Issues Loss of Consciousness
 Numbness Weakness Tingling Dizziness Severe Headache
 - Endocrine: Fatigue Increased Thirst Cold Intolerance Heat Intolerance
 - Hematologic: Frequent Nose Bleeds Easy Bruising Easy Bleeding Swollen Hands/Feet Swollen Glands
 - Immunologic: Recurrent Infections Sneezing Itchy Eyes
 - Psychiatric: Depression/Anxiety Mood Swings Emotional Changes Substance Abuse Suicide Attempts
- No to all

PAST MEDICAL HISTORY

- Anemia
 - Anxiety Disorder
 - Arthritis
 - Asthma
 - Bleeding Disorder
 - Blood Clot
 - Cancer
 - Coronary Artery Disease
 - Depression
 - Diabetes
 - GERD/Reflux
 - Gastrointestinal Ulcers
 - Gout
 - HIV or AIDS
 - Heart Attack
 - Heart Disease
 - Heart Problems
 - Hepatitis
 - Hernia
 - Hypertension
 - Hyperthyroidism
 - Hypothyroidism
 - Kidney Disease
 - Leg or Foot Ulcers
 - Liver Disease
 - Lung Disease
 - Migraines
 - Osteoporosis
 - Pacemaker
 - Peripheral Vascular Disease
 - Pulmonary Embolism
 - Rheumatoid Arthritis
 - Seizures/Epilepsy
 - Stroke
 - Tuberculosis
 - Other: _____
- No to all



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Patient General Health Form

Name: _____

Date: MM / DD / YYYY

GENERAL INFO	Last Name		First		MI	Birth Date MM / DD / YYYY	
	Height	Weight	Are You Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ months			Living Arrangement <input type="checkbox"/> Alone <input type="checkbox"/> With Others	
	Employer		Occupation		School/Team		Team/Sport
	Exercise Level <input type="checkbox"/> None <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy				Hand Dominance		Sporting Activities
	Use of tobacco products <input type="checkbox"/> Never <input type="checkbox"/> In the Past <input type="checkbox"/> Currently; _____ packs/day				Illicit Drug Use <input type="checkbox"/> No <input type="checkbox"/> Yes; Type(s): _____		
	Alcohol Consumption <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy _____ drinks/week						

ALLERGIES	Are you allergic to any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes							
	Medication		Reaction		Medication		Reaction	
	Medication		Reaction		Medication		Reaction	

PREVIOUS SURGERY	Please list any surgeries or hospitalizations you have had in the past <input type="checkbox"/> None			
	Surgery/Illness		Hospital	Year
	Surgery/Illness		Hospital	Year
	Surgery/Illness		Hospital	Year

CURRENT MEDICATIONS	Please list all current medications <input type="checkbox"/> None				
	Medication	Dosage	Frequency	Reason	Prescribed
	Medication	Dosage	Frequency	Reason	Prescribed
	Medication	Dosage	Frequency	Reason	Prescribed
	Medication	Dosage	Frequency	Reason	Prescribed

FAMILY HISTORY	Family Member		Health Issue	<input type="checkbox"/> Deceased
	Family Member		Health Issue	<input type="checkbox"/> Deceased
	Family Member		Health Issue	<input type="checkbox"/> Deceased

SIGNATURE	<i>I certify that the facts contained on this form are true and complete to the best of my knowledge.</i>		
	Signature _____	Printed Name _____	Date _____



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Patient Financial Responsibility Form

Date: MM / DD / YYYY

FINANCIAL RESPONSIBILITY

I understand that payment in full is expected at the time services are rendered. If prior arrangements have been made, Athletic Orthopedics and Knee Center (AOKC) may bill my insurance company for the estimated portion. This is a courtesy to me and I am responsible for the total payment of all charges regardless of insurance coverage.

Since some insurance carriers are unnecessarily delaying payment of claims, I may be called upon for payment if Athletic Orthopedics and Knee Center has not received payment within 60 days of billing. If Athletic Orthopedics and Knee Center receives any subsequent payment from my insurance company, then a credit balance will be promptly refunded to me.

I understand that my insurance is a contract between me, my employer and the insurance company. Athletic Orthopedics and Knee Center is not a party to that contract and cannot be responsible for negotiating payment.

I hereby authorize my insurance benefits to be paid directly to Athletic Orthopedics and Knee Center realizing I am responsible for payment as stated above.

I hereby authorize Athletic Orthopedics and Knee Center to release medical information pertaining to my claim to my insurance company, third party payor and/or my attorney. There is a fee for copying medical records. Unless otherwise specified, I authorize AOKC to access a national pharmacy database for my medication history.

Signature

Date

MEDICAL RELEASE

I hereby authorize Athletic Orthopedics and Knee Center to release medical information pertaining to my claim to my insurance company, third party payor and/or my attorney. There is a fee for copying medical records.

Signature

Date

PRIVACY PRACTICE

I have read the Privacy Practice documented by Athletic Orthopedics and Knee Center.

Signature

Date