PATIENT INFORMATION FORM

First Name_____ MI_____ Last_____ Preferred Name_____ CHART #: _____

Home address: _____

City: _____ State: _____ Zip code: _____SSN: _____

Home Phone#:_____ Cell #: _____ Work #: _____

Date of Birth: _____ Age ____Gender_____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email address: _____

Race: ☐White ☐Black ☐Other Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Unknown

RESPONSIBLE PARTY (BILL TO) INFORMATION:

First Name: _____Middle: _____ Last:_____

Address: _____ City, State, Zip: _____

Home #:_____ Cell #: _____ Work #:_____

SSN: _____ Relationship to Patient: _____ DOB: _____

Emergency Contact Name_____ Relationship_____

Home #: _____ Cell #: _____ Work #: _____

How did you hear about SSO? ☐ Friend/Family ☐ Referral ☐ Walk/Drive by ☐ Internet ☐ Other_____

How would you like to receive courtesy appointment reminders? ☐ E-mail ☐ Phone Call ☐ Text message

Referring Provider_____ Primary Care Provider _____ ☐ OK to send records to PCP

PRIMARY INSURANCE OR SELF-PAY

Insurance Company Name _____ Policy # _____

Policy Holder Name _____ Date of Birth _____

Relationship to Patient _____ Policy Holder SSN _____-_____-_____

Secondary Insurance Name _____ Policy # _____

CONSENT FOR TREATMENT

I, the undersigned, give permission to the practitioner/s of 7 Springs Orthopedics and/or Physical Therapy, to administer evaluation and treatment necessary and advisable for my condition. If patient is a minor, a parent or guardian must sign. **Consent must be signed before we begin treatment.**

_____

Signature of Patient (or Legal Guardian) Date

7 springs ORTHOPEDICS

7 springs PHYSICAL THERAPY

Patient Name_____DOB: _____ Date _____CHART #: _____

MEDICAL HISTORY INTAKE FORM

Height:_____ Weight:_____ Injury Date: _____

Referring doctor: _____Primary Care Doctor: _____ ☐ OK to send records to PCP

What are you being seen for today (include right or left body part):_____

Work Related: __YES __NO Reported to Employer: ___YES ___NO Attorney Name (if applicable): _____

SYMPTOMS: Rate your pain level on a scale of 1-10: 0 = no pain, 10 being the worst pain ever experienced: _____

Describe your symptoms: _____

Symptoms Are: ☐MILD ☐MODERATE ☐SEVERE Symptoms Are: ☐CONSTANT OR ☐INTERMITTENT

Other symptoms associated to this injury include: *(check (✓) all that apply)*?

☐ None ☐ Fever ☐Chills ☐ Weight Loss ☐Numbness ☐ Tingling ☐ Swelling ☐ Locking ☐ Giving Way

When did your symptoms begin? _____

What occurred for these symptoms to begin? _____

What makes you feel better? _____

What makes you feel worse? _____

What **Treatment & Testing** have you received *(check (✓) all that apply)*? ☐ X-ray ☐ MRI ☐ CT Scan ☐ Nerve Conduction/EMG ☐ Bone Scan ☐ Bone Density Scan ☐ Bloodwork Labs ☐ Myelogram ☐ Chiropractic ☐ Physical Therapy ☐ Occupational Therapy ☐ Bracing ☐ Orthotics ☐Medication ☐ Injections ☐ Other: _____

MEDICAL HISTORY/REVIEW OF SYMPTOMS *(check (✓) all that apply*

☐	Asthma or breathing issues	☐	Anemia	☐	Bleeding Disorders
☐	Arthritis	☐	Cancer	☐	Cirrhosis/ Liver Disease
☐	Depression	☐	Multiple Sclerosis	☐	Circulation Problems
☐	Diabetes	☐	High Blood Pressure	☐	Epilepsy
☐	Hepatitis	☐	Heart Problems	☐	Stroke
☐	Stomach Ulcers	☐	Tuberculosis	☐	Rheumatoid Arthritis
☐	Kidney Disease	☐	High Cholesterol	☐	Headaches
☐	Hemophilia or Slow Healing	☐	Osteoporosis	☐	Scoliosis
☐	HIV	☐	Gout	☐	Fibromyalgia
☐	Hypo/Hyperthyroidism	☐	Renal Dialysis	☐	Sleep Apnea
☐	Angina/Chest Pain	☐	Lung Disorder	☐	Other

7 springs ORTHOPEDICS

7 springs PHYSICAL THERAPY

Patient Name_____ Date _____CHART #: _____

Check all **Surgeries** that you have had in the past:

☐ Joint Surgery ☐ Spine Surgery ☐ Heart Surgery ☐ Hysterectomy ☐ C-Section

☐ Tonsillectomy ☐ Appendectomy ☐ Gallbladder ☐ Other: _____

FAMILY HISTORY:

Check all health problems that blood members of your family have had and list the relative(s):

☐ Arthritis:_____ ☐ Osteoporosis: _____

☐ Cancer: _____ ☐ Diabetes: _____

☐ Scoliosis: _____ ☐ Heart Disease: _____

☐ Stroke: _____ ☐ Bleeding Disorder: _____

☐ Blood Clots: _____ ☐ Hypertension: _____

☐ Other: _____

Social History

Do you smoke? ☐YES ☐NO Number of packs/day: _____

Do you drink alcohol? ☐YES ☐NO Number of drinks/day:_____

Have you been treated for, or do you currently have a problem with alcohol, illegal drug use, or prescription drug abuse? ☐YES ☐NO

Please list any other Physician prescribed medication you are currently taking (including pills, injections and/or skin patches, as well as the dosage and frequency). If more than 9, please attach a list and initial below.

☐List Attached Patient initials _____ Provider initials _____

1._____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

7._____ 8. _____ 9. _____

ALLERGIES:

List the names of any medications you are allergic to and what side effects you have when taken: _____

_____

☐ NO KNOWN ALLERGIES ☐ LATEX ALLERGY Provider's review & Date: _____