# 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.**

7SO participates in programs giving students and volunteers the opportunity to experience and engage in our clinical practice. Your provider has agreed to permit such students to observe and participate in his/her patient care activities

where appropriate. By signing below, you agree to permit the students working in your providers office to observe and participate in your medical care during your appointment today, including, where appropriate, providing direct medical care to you under your provider's direct supervision. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

_____

Signature of Patient (or Legal Guardian) Date

Patient Name_____DOB: _____ Date _____CHART #: _____

7 springs ORTHOPEDICS

7 springs PHYSICAL THERAPY

# MEDICAL HISTORY INTAKE FORM

Patient Name: First_____Last _____Middle_____CHART #_____

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: _____