TEXAS ORTHOPEDICS, SPORTS AND REHABILITATION ASSOCIATES

Name: ______________________ **Appt Date:** __________ **With Doctor:** __________

Age: _______ **Sex:** ☐ Male ☐ Female **Dominant Hand:** ☐ Right ☐ Left **Height:** __________

Who is your primary physician? ______________________; **Clinic Name:** ______________

WHO REFERRED YOU TO OUR OFFICE?

Staff Use Only
Wt

☐ Doctor ______________________ ☐ Friend ______________________

☐ Coach/Trainer ______________________ ☐ Hospital/ER ______________________

☐ Phone Book ☐ Website ☐ Insurance Plan ☐ Other ______________________

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS

What is your chief complaint and location of pain? ______________________ ☐ Right ☐ Left

How long have you had this problem? _______ days _______week(s) _______month(s) _______years(s)

How did the injury occur (if applicable): ______________________ ***(please complete full details on Accident/Injury page)***

On a scale of 0-10 how severe is your pain? None - 0 1 2 3 4 5 6 7 8 9 10 – Severe

Quality of Pain: ❑ Sharp ❑ Dull ❑ Aching ❑ Throbbing ❑ Burning ❑ Knots ❑ Electric Shocks ❑ Numbness ❑ Tingling

The Pain is: ❑ Constant ❑ Intermittent (off and on) ❑ Wakes me at night

Do you have any of the following associated symptoms: ❑ Swelling ❑ Popping (audible/feel) ❑ Catching ❑ Locking ❑ Giving Way ❑ Stiffness ❑ Numbness ❑ Tingling ❑ Weakness ❑ Loss of bowel or bladder control

What makes your symptoms <u>worse</u>? ❑ Standing ❑ Walking ❑ Running ❑ Exercise ❑ Sitting ❑ Lifting ❑ Twisting ❑ Stairs ❑ Lying in bed ❑ Bending ❑ Squatting ❑ Kneeling ❑ Coughing ❑ Sneezing ❑Rising from a chair

What treatments and/or surgery have you had for this problem?

❑ Rest	___Helpful	___Not Helpful	❑ Therapy	___Helpful	___Not Helpful
❑ Elevation	___Helpful	___Not Helpful	❑ Medication	___Helpful	___Not Helpful
❑ Heat	___Helpful	___Not Helpful	❑ Injection	___Helpful	___Not Helpful
❑ Cold	___Helpful	___Not Helpful	❑ Cane	___Helpful	___Not Helpful
❑ Brace/Bandage	___Helpful	___Not Helpful	❑ Crutch	___Helpful	___Not Helpful

What tests have you had for this problem? ❑ Xrays ❑MRI ❑CT Scan ❑ Bone Scan ❑ EMG/NCV ❑ Where?________

<u>REVIEW OF SYSTEMS</u> (Please only check **CURRENT** problems)

Constitutional	❑None	❑ Weight Loss	❑ Loss of appetite			
Eyes	❑None	❑ Blurred Vision	❑ Double Vision	❑ Vision loss	❑ Eye discomfort	❑ Dryness
Ears-Nose-Throat	❑None	❑ Trouble swallowing	❑ Hoarseness	❑ Hearing loss	❑ Nosebleeds	
Cardiovascular	❑None	❑ Chest pain	❑ Irregular heartbeat	❑ Palpitations	❑ Calf Pain	
Respiratory	❑None	❑ Shortness of Breath	❑ Chronic cough	❑ Wheezing		
Gastrointestinal	❑None	❑ Heartburn	❑ Ulcers	❑ Nausea, Vomiting	❑ Blood in stool	❑ Diarrhea
Genitourinary	❑None	❑ Painful urination	❑ Blood in urine	❑ Difficult urination	❑ Frequent at night	❑ Possible pregnancy
Skin	❑None	❑ Frequent rashes	❑ Skin ulcers	❑ Psoriasis	❑ Lumps	
Neurological	❑None	❑ Headaches	❑ Dizziness	❑ Seizures	❑ Memory difficulties	❑ Numbness
Musculoskeletal	Do your other joints have: ❑ Morning stiffness lasting over 30 minutes? ❑ Joint pain or swelling? ❑ Back/neck pain ❑ Gout					
Endocrine	❑None	❑ Heat or Cold intolerance	❑ Excessive thirst			
Psychological	❑None	❑ Depression	❑ Anxiety	❑ Difficulty sleeping	❑ Other psychiatric disorder	
Hematologic	❑None	❑ Easy bleeding	❑ Easy Bruising	❑ Swollen glands		

PLEASE SIGN: The information on this form in its entirety is accurate to the best of my knowledge.

Signature ______________________________________ **Date** ______________

If other than patient, relationship to patient ______________________

Name: ______________________________ (please print) Acct #: _________________ Dr: ______________

PAST MEDICAL HISTORY

Do you now or have you ever had any of the following:

❑ Addiction
❑ Alcoholism
❑ Anemia
❑ Anxiety disorder
❑ Asthma
❑ Bleeding problems
❑ Cancer (Specify):____
❑ CVA (Stroke)
❑ Colitis
❑ Depression
❑ Diabetes
❑ Epilepsy
❑ Fibromyalgia
❑ Gastric Ulcer
❑ Gout
❑ Heart disease
❑ Hepatitis
❑ History of blood clots
❑ HIV/AIDS
❑ Hypertension
❑ Kidney disease/stones
❑ Lung disease/COPD
❑ Lupus
❑ Migraine
❑ MRSA
❑ Problems w/anesthesia
❑ Rheumatoid arthritis
❑ Thyroid disease

Other significant illness (please list): ____

FAMILY HISTORY

Have any direct relatives (mother/father/sister/brothers/children) had any of the following disorders? If so, who?

History	Relative	History	Relative	History	Relative
❑ Anesthesia Reaction		❑ Heart disease		❑ Osteoarthritis	
❑ Bleeding Disorders		❑ Hepatitis		❑ Rheumatoid Arthritis	
❑ Blood Clots		❑ Hypertension		❑ Thyroid Disease	
❑ Cancer		❑ Irregular heartbeat		❑ Ulcers	
❑ Diabetes		❑ Kidney Disease			
❑ Epilepsy		❑ Lupus			

Do any direct relatives have the same condition you are being seen for today? ❑ No ❑ Yes; who?________________

SOCIAL HISTORY

Do you use Tobacco? ❑ No ❑ Yes ❑ Past – How long ago? _______________ if yes, how much? _____________

Do you drink Alcohol? ❑ No ❑ Yes If yes, how often? ❑ Daily ❑ _____/week ❑ Other:__________________

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list:________________________

Employment Status: Occupation?____________________________Employer:________________________

Employed: ❑ Full Time ❑ Part Time ❑ Self employed ❑ Disabled ❑ Retired **Student:** ❑ Full Time ❑ Part Time

Current work status? ❑ Full Duty ❑ Light Duty ❑ Not working due to this problem (How long? ________________)

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other__________

Do you exercise? ❑ No ❑ Yes; 1-3 times/week ❑ Yes; 4 or more times/week ❑ Yes; active but no formal exercise

If yes, what type?________________________ What Sports do you participate in? ______________________________

SURGERIES

Description of surgery	Date	Results/Complications

Pharmacy of choice name, number and location:

____

DRUG ALLERGIES: ❑ No ❑ Yes To what? ____

Type of reaction: ____

Name: ______________________________ **(please print) Acct #:** _________________ **Dr:** ______________

PRESENT MEDICATIONS INCLUDING OVER-THE-COUNTER:

Drug Name & Dose/Strength	Frequency or number of pills per day	Start Date?	Reason for taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

ACCIDENT / INJURY DETAILS

Date of accident/injury: ________________________________

Current problem is the result of (check all that apply) ❑ Car Accident ❑ Work Accident ❑ Accident
❑ Other ____

Describe how your accident/injury occurred: ____
____

Location of accident/injury was: ____

Were you on the job or was it related to work? ❑ No ❑ Yes
If yes, Employer's name: ______________________________________ Ph#: ______________
Did you report it to your employer? ❑ Yes ❑ No If self employed, do you carry an accident policy? ❑ Yes ❑ No

If you were NOT in an auto accident, complete this section:
Did your injury occur on someone else's property? ❑ Yes ❑ No
Name and tel. # of property owner ____
Adjustor Name ____ Phone # ______________ Claim # ______________

Complete this section if there was an auto accident:
I was: ❑ a driver ❑ a passenger ❑ a pedestrian
My auto insurance company is: ____
Adjustor Name ____ Phone # ______________ Claim # ______________

Do you intend to make any claims other than Health Insurance? ❑ Yes ❑ No
Have you hired an attorney because of the accident? ❑ Yes ❑ No
Attorney Name ____ Phone # ______________________
Attorney Address ____

The information on this page is accurate to the best of my knowledge.

Patient's Name: ________________________________ Signature: ______________________________________

Print Signature if Parent or Guardian (for minor) ____________________________________