Welcome to Non-Surgical Orthopedics

Patient Information

Today's Date_____

First Name_____MI____Last_____

Address_____

City _____STATE _____ ZIP_____

Birthday _____ Age____ S.S.# _____

Home Tel. (____) _____Cell (____) _____ Work (____) _____

Employer: _____ Occupation: _____

Emergency Contact: _____ **Phone:** _____

Please present a copy of the insurance card for each carrier

Primary Medical Insurance Company

Insurance Name: _____PolicyID_____

Policy Holder: _____Group ID_____

Date of Birth: _____SS# _____ MALE or FEMALE

Relationship CHOOSE ONE: Self Spouse Child Other _____Employer: _____

Secondary Medical Insurance

Insurance Company Name: _____Tel: _____

Insured's Name (if different that patient):_____DOB: _____

Address: _____ Tel: _____

Member ID: _____ GroupID:_____SS#:_____

Employer: _____ Tel:_____

Primary Care Physician_____Tel:_____

Who referred you to us?

_____

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Name: _____ Date of Birth: _____

Medical History Have you ever had the following? Please check all that apply!

___Heart disease	___Metal implants	___Anemia	___Migraines
___Diabetes	___Cancer	___Herniated disc	___Gout
___Epilepsy	___Thyroid disease	___Psychiatric disorder	___Stomach Ulcers
___Liver disease	___HIV/AIDS	___Hepatitis	___Pacemaker
___Kidney disease	___Stroke	___Osteoporosis	___Scoliosis
___Lung disease	___Blood Clots	___Brain Injury	___Spinal Injury

Please list any other conditions you would like to tell us about. (including musculoskeletal):

_____

_____

Family History Please check off if your relatives have had any of the following diseases.

Disease	Father	Mother	Brother/Sister	Grandparents
Arthritis	⬭ _____	⬭ _____	⬭ _____	⬭
Cancer	⬭ _____	⬭ _____	⬭ _____	⬭
Heart Disease	⬭ _____	⬭ _____	⬭ _____	⬭
Neurological Disease	⬭ _____	⬭ _____	⬭ _____	⬭

Social History

What are your hobbies? _____

What is your marital Status?	Single	Married	Widowed	Divorced
Do you smoke/chew tobacco?	Never	Social	Less than pack/day	More than pack/day
Do you drink alcohol?	Never	Occasionally	Regularly	Daily
Do you use recreational drugs?	Never	Occasionally	Regularly	Daily

Surgeries/Foreign Materials eg. Pacemaker, metal etc.

_____

_____

_____

Current Medications: Please include all prescriptions, over-the-counter medications, vitamins and herbal supplements.

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

7._____ 8. _____

9._____ 10. _____

Allergies to medication, food, or other. Please list allergy and state the reaction you had.

1._____ 2. _____

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Name_____

Traumatic Injuries **Please list all (if any):**

_____

Are you having any of these symptoms? Please check off all that apply:

General:
___Anxiety
___Depression
___Ear Ache/Noise
___Fatigue
___Fever
___Loss of bladder
___Sleep Loss
___Skin Rash
___Weight Loss/Gain

Eyes, Ears, Nose, Throat:
___Earache/Noise
___Failing Vision
___Sinus Infection
___Enlarged Glands

Cardiovascular:
___Swelling Legs
___Pain over heart

Gastro:
___Nausea
___Pain over stomach

Musculoskeletal:
___Arm/Leg Pain
___Arm/Leg Weakness
___Painful/Swollen Joints
___Low Back Pain
___Neck Pain
___Sciatica

Neurological:
___Convulsions
___Headaches
___Numbness

Respiratory:
___Chronic cough
___Difficulty breathing

Reason for your visit:_____

Describe your condition: _____

Have you had any tests for your **current condition**? (mark all that apply, give date & results)

o X-rays_____ o MRI _____ o CT Scan _____ o CT Myelogram_____ o EMG _____

_____

Is this condition the result of an accident?

Yes No (If yes, please indicate) Work Auto Other _____ Date of Accident:_____

Women Only:
Are you pregnant or is there any possibility that you could be pregnant? **Yes** **No**

By my signature below, I hereby specifically authorize the physician and/or his agents to provide medical treatment to me. I also authorize Non-Surgical Orthopedics and/or Michael R. Hadley D.O. to release any medical and personal information acquired in the course of treatment that is necessary to process insurance claims, or receive payment from any payment entity and authorize my insurance company to make the payments for my medical services directly to the physician, realizing that I am responsible for any amount not covered/paid by my insurance. I also authorize the practice to release information that is requested by any physical therapy, diagnostic imaging, labs or other physicians that the practice refers me to as part of my treatment.

Patient Signature_____ Date: _____

Guardian Signature_____Date: _____