



INTAKE FORM

Patient Name: _____ DOB: _____

Phone number verification (please list):

Home _____ Cell _____ Work _____

Race (circle one, or more, if applicable):

American Indian or Alaskan Native Asian Black or African American
Native Hawaiian or other Pacific Islander White Decline

Ethnicity (circle one): Hispanic Origin Non-Hispanic Origin Decline

Preferred Language: _____ Decline

Smoking Status: (select one)

- Current every day smoker Current some day smoker Former smoker Never smoker
- Heavy tobacco smoker Light tobacco smoker Smoker, current status unknown Unknown if ever smoked

If a current smoker, what year did you start? _____ Number of packs per day? _____

If a former smoker, what year did you start? _____ What year did you stop? _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Patient Signature

Date



CONSENT FORM

Patient Name: _____ DOB: _____

- Consent to Diagnose and Treat. I hereby consent to diagnostic and medical treatment by SportsMed-Wheaton Orthopaedics' physicians and/or their designated staff. I understand that any procedure (such as injections, I&D, parings, etc.) has risks, which include but are not limited to infection, bleeding, pain and/or swelling.
- Electronic Prescriptions. I agree that SportsMed-Wheaton Orthopaedics may request and use my prescription medication history from other healthcare providers or third party pharmacy payers for treatment purposes.
- Assignment of Benefits and Agreement to Pay. I understand I am financially responsible for any co-payments, deductibles, coinsurance, medical supplies and equipment, or any other amounts not covered by my insurance. I authorize direct payment to SportsMed-Wheaton Orthopaedics for all covered services, equipment and supplies. I understand it is my responsibility to obtain referrals from my primary care physician if required by my plan. It is my responsibility to contact my insurance company with any questions regarding eligibility and coverage. Payment is due within 30 days of receipt of statement. In the event legal action must be taken to collect any balance due, I will be responsible for the cost of collection and reasonable legal fees related to my account.
- Consent for Release of Information for Payment. I hereby authorize SportsMed-Wheaton Orthopaedics to release to my insurance companies, government agencies, employer or third party payers and their agents, information concerning my medical care and treatment, supplies or other information necessary to determine eligibility and benefits and to obtain payment for healthcare services rendered to me. I also consent for release of information needed to complete FMLA and Disability Forms.
- Notice of Privacy Practices. I hereby acknowledge receipt of SportsMed-Wheaton Orthopaedics' Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential health information. I understand the practice has the right to change its privacy practices described in the Notice and that a copy of any Revised Notice will be made available in the office or at www.sportsmedltd.com.
- Financial Policy. I have received and agree with the SportsMed-Wheaton Orthopaedics Financial Policy.
- Patient Communicator. I agree SportsMed-Wheaton Orthopaedics may use my e-mail address to activate the Patient Portal. This allows me to view my clinical information and communicate with my doctor electronically or _____ I decline the Patient Portal.
X to decline

My email address is: _____

- I give permission for SportsMed-Wheaton Orthopaedics to leave messages at the phone numbers I have provided.
- My **preferred** phone number for **medical messages** is (circle **one**):

Home	Cell	Work
Phone	Phone	Phone
- I give permission for SportsMed-Wheaton Orthopaedics to leave messages or discuss information with the people listed below:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

X _____
Signature of patient or authorized representative or Parent or legal guardian if patient is a minor Date _____

Name of parent or authorized representative (please print) Relationship to patient _____

Only if Patient is a Minor (< 18 years old) or Dependent Adult complete the following section. List <u>all</u> parties you are giving permission for SportsMed-Wheaton Orthopaedics to discuss information or leave messages with regarding this patient:	
Mother's Name: Mother's Telephone Number: Home Work Cell ()	Father's Name: Father's Telephone Number: Home Work Cell ()
Step-Mother's Name: Step-Mother's Telephone Number: Home Work Cell ()	Step-Father's Name: Step-Father's Telephone Number: Home Work Cell ()
Other's Name: Relationship to Patient: Other's Telephone Number: Home Work Cell ()	Other's Name: Relationship to Patient: Other's Telephone Number: Home Work Cell ()

Health History

Name: _____ DOB: _____ Age: _____ Male Female

Height: _____ Weight: _____ Right Handed Left Handed

Primary Care Physician: _____ Phone: _____

Address: _____

Your Medical History (Check all that apply)

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack/Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes Type ____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Clot/DVT | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer Type _____ | <input type="checkbox"/> Esophageal Reflux/GERD | <input type="checkbox"/> HIV | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Other (List): _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Parkinson's Disease | _____ |

In the past 12 months

Have you had a fall that resulted in an injury? NO YES

Have you had a bone density test (Dexascan)? NO YES

Surgeries/Hospitalizations

Year	Surgery/Hospitalization

Year	Surgery/Hospitalization

Have you had any problems with anesthesia? NO YES If yes, explain _____

Allergies

No Allergies Yes (List allergy and type of reaction)

<input type="checkbox"/> Latex	Reaction _____
<input type="checkbox"/> Penicillin	Reaction _____
<input type="checkbox"/> Sulfa	Reaction _____

<input type="checkbox"/> Egg Products	Reaction _____
<input type="checkbox"/> Metal	Reaction _____
<input type="checkbox"/> Other:	_____

Medication History (List all prescriptoin drugs, vitamins, supplements, over the counter meds)

	<u>Medication</u>	<u>Strength</u>	<u>When do you take it?</u>	<u>Reason you take it</u>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Review of Systems (Check any symptoms you have had in the past month)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Hearing Changes | <input type="checkbox"/> Bleeding/Blood Clots | <input type="checkbox"/> Chest Pain/Palpitations |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Other: _____ |

Social History

Marital Status (circle one): Single Married Widowed Separated Divorced Significant Other

Do you live alone? NO YES

Do you use Alcohol? NO YES # Drinks/Week: _____

Currently Smoking? NO YES

Do you use recreational drugs? NO YES

Occupation: _____ Name of work Facility: _____

What exercise, sports or recreational activities do you participate in? _____

Family Medical History (Has any parent, child or sibling had any of the following? If yes, specify who.)

- | | | | |
|----------------------|-----------------------------|------------------------------|------------|
| Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who: _____ |
| Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who: _____ |
| High Blood Pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who: _____ |
| Rheumatoid Arthritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who: _____ |
| Stroke | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who: _____ |

Signature of patient or authorized representative or
Parent or legal guardian if patient is a minor

Date

Print Name of parent or authorized representative

Relationship to patient

New Problem Form

Name: _____ DOB: _____ Referred By: _____

Body Part: _____ RT LT Both How long have you had problem? _____

If an injury occurred: Date of Injury _____ Where did injury occur? Home Work Other _____

Describe what happened: _____

Off work due to injury? NO YES If yes, last day worked: _____ Work Restrictions: _____

Pain: (Check all that apply or describe) _____

Type: Sharp Dull Throbbing Burning Aching Is your pain constant? NO YES

Severity: Mild Moderate Severe Does your pain radiate? NO YES If so, where? _____

Symptoms: (Check all that apply or describe) _____

- | | | | |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> Instability | <input type="checkbox"/> Swelling | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Clicking/Grinding |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Stiffness/Limited Motion | <input type="checkbox"/> Catching/Locking | <input type="checkbox"/> Discoloration |

Any prior treatment for this problem? NO YES If yes, by whom? _____ When? _____

Tests done (check) X-ray MRI Other: _____ When/where was test done? _____

Brace, orthotic or assistive device? NO YES If yes, what type? _____

Do you use (check)? Cane Walker Wheelchair Crutches Splint Cast

Activities that aggravate symptoms:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Up from chair/bed | <input type="checkbox"/> Running/Jumping | <input type="checkbox"/> Kneeling/Squatting | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Stairs | <input type="checkbox"/> Repetitive Motion | <input type="checkbox"/> Stooping/Bending | <input type="checkbox"/> Overhead movements |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Lifting/Carrying | <input type="checkbox"/> Standing | Other _____ |

Treatments that alleviate symptoms:

- | | | | |
|------------------------------|-------------------------------|-------------------------------|-------------|
| <input type="checkbox"/> Ice | <input type="checkbox"/> Heat | <input type="checkbox"/> Rest | Other _____ |
|------------------------------|-------------------------------|-------------------------------|-------------|

Medications you have taken for this problem:

<u>Medication</u>	<u>Does it help?</u>	<u>How long have you been on it?</u>
1. _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
2. _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Signature of patient or authorized representative or
Parent or legal guardian if patient is a minor

Date

Print Name of parent or authorized representative

Relationship to patient