THE ORTHOPEDIC INSTITUTE of NEW JERSEY

Patient Information

Date___________________

Patient____

Address ____

____

____

City State Zip

Sex: □Male □Female Age______ Birthdate____________

Patient SS#_______________________________________

Occupation____

Whom may we thank for referring you? _____________

____

Primary Care Physician____________________________

Phone Number______________________________________

Phone Numbers

Home____

Cell____

Work____

In Case of Emergency, Contact:

Name____

Phone Number______________________________________

Accident Information

Is Condition Due to Accident? □Yes □No

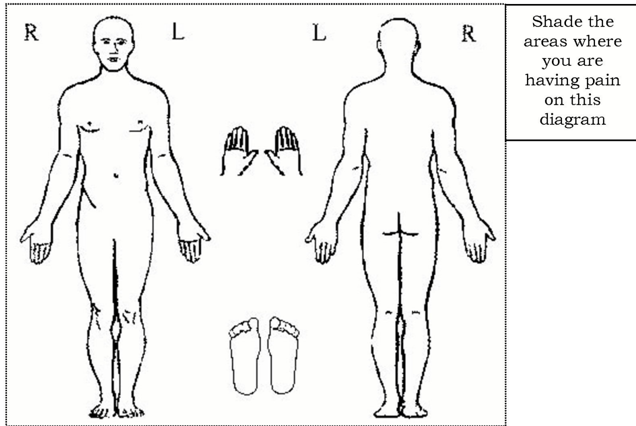
Type of Accident □Auto □Work □Other

Insurance Co.________________D.O.A________________

Case Worker Name__________________________________

Phone Number______________________________________

Claim Number______________________________________



Shade the areas where you are having pain on this diagram

Please check if you are:

□ Single □ Married □ Separated □ Divorced □ Widowed

Habits

□ Smoking Packs/Day__________________

□ Alcohol Drinks/Week_______________

□ Coffee/Caffeine Drinks Cups/Day_________________

□ High Stress Level Reason___________________

Are you pregnant?

□ Yes □ No

Due Date______________________________

Patient Condition

Reason for Visit____

When did your symptoms appear?____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Rate the severity of your pain on a scale from 1(least pain) to 10(severe pain) ________________

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting

□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other ____________________

How often do you have the pain?____

Is it constant or does it come and go?____________________________________

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

Health History

What treatment have you already received for your condition? □ Medications □ Surgery
□ Physical Therapy □ Chiropractic Services □ None □ Other_____________________________________

Date of last: Physical Exam_______________ Spinal XRay________Location__________________________

Chest XRay_____________MRI,CTScan,BoneScan________________Location__________________________

Place a mark to indicate if you have had any of the following:

- □ AIDS/ HIV
- □ Alcoholism
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Bleeding Disorders
- □ Cancer
- □ Cataracts
- □ Chemical Dependency
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Fractures
- □ Glaucoma
- □ Gout
- □ Heart Disease
- □ Hepatitis
- □ Hernia
- □ Herniated Disc
- □ Herpes
- □ High Blood Pressure
- □ High Cholesterol
- □ Kidney Disease
- □ Liver Disease
- □ Migraines
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Mumps
- □ Osteoporosis
- □ Pacemaker
- □ Parkinson's Disease
- □ Pneumonia
- □ Pneumatic Fever
- □ Prostate Problem
- □ Prosthesis
- □ Psychiatric Care
- □ Rheumatoid Arthritis
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tuberculosis
- □ Tumors, Growths
- □ Ulcers
- □ Venereal Disease
- □ Other ____________________

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Please List Medications	/Allergies
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
Pharmacy Name______________________	______________________________
Pharmacy Number______________________	______________________________

Injuries/Surgeries you have had	Description	Date
Falls	______________________________	______________
Head Injuries	______________________________	______________
Broken Bones	______________________________	______________
Dislocations	______________________________	______________
Surgeries	______________________________	______________