ORTHONOW PATIENT INTAKE

DEMOGRAPHICS:	
Patient Name: _____ Date of Birth: ____ /____ /____ Do you have a defibrillator? Y / N Do you have a pacemaker? Y / N Are you claustrophobic? Do you have any metal in your body?	Height: _____ Weight: _____

Release of Information: Would you like to authorize an individual to obtain confidential information regarding todays visit? If yes, please provide information below.

Name _____

Phone Number _____

REASON FOR VISIT:
Chief Complaint: _____ Have you had surgery on the specified area in the last 90 days? Y / N Did you bring outside imaging to this visit? Y / N **IF YES PLEASE SEE THE FRONT DESK IMMEDIATLY**

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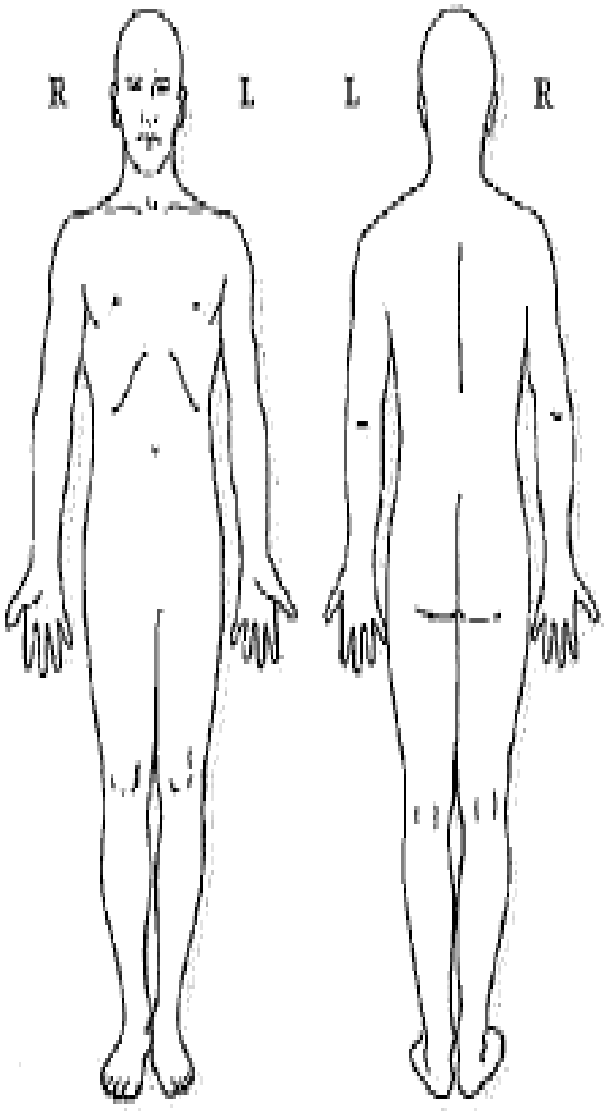
PAIN DIAGRAM: Please indicate areas of pain, numbness, tingling, and/or injury on the following diagram.

Pain = P Numbness = N Tingling = T Injury = I



SEVERITY: How severe is your pain?

(Circle #)

0	123	4567	8910
No Pain	Mild	Moderate	Severe

NATURE: Pain is

□ Occasional
□ Continuous
□ Intermittent
□ Sharp
□ Shooting
□ Aching
□ Dull
□ Improving
□ Worsening
□ Unchanged

EFFECT ON DAILY LIFE:

□ Wake up at night?
□ Interferes with work activities?
□ Interferes with recreational activities?
□ _____

INCREASING/DECREASING FACTORS:

What makes the pain worse?

□ Activity □ Work □ Exercise
□ _____

What makes the pain better?

□ Rest □ Heat □ Ice
□ _____

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DETAILS OF CURRENT INJURY:

How did the injury/symptoms occur?

□ Previous Injury/Recurrence □ New Injury

Where did the injury occur?

□ Home □ Work □Sports/Recreation □ Vehicle (MVA) □ Other _____

How long have you had this symptoms/injury?

Date of Injury: ___ / ___ / ___ Duration? _____

CURRENT MEDICATIONS:	**ALLERGIES:**
Please list name/dosage of any medications you are currently taking including prescription, over the counter, herbals: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____ 13. _____ 14. _____ 15. _____	Please list any/all drug and food allergies: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____ 13. _____ 14. _____ 15. _____

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PREFERRED PHARMACY:
Name: _____ Address: _____ Phone Number: _____

ADDITIONAL INFORMATION:
List any previous medical care for this issue: □ Treating Dr _____ □ Facility_____ □Date_____ □ Treating Dr _____ □ Facility_____ □Date_____ □ Treating Dr _____ □ Facility_____ □Date_____ □ Treating Dr _____ □ Facility_____ □Date_____ Additional Comments: _____

I certify that to the best of my knowledge, all information listed is true. I further certify that I have not falsified or intentionally omitted any information related to my health or past medical history.

Signature of patient/guardian: _____ Date: _____