1702 W. Fairview Ave Boise, Idaho 83702 Phone: (208) 957-7400 Fax: (877) 287-3117 frontdesk@gustavelorthopedics.com

PATIENT DEMOGRAPHICS

_____ _____ _____ _____
Legal First Name | Legal Last Name | Middle Initial | Maiden Name

_____/_____/_____ _____
Date of Birth | Age

_____ _____ _____ _____ _____
Billing Address | Apt. # | City | State | Zip

_____ _____
Primary Phone number | Additional Phone Number

How would you like to receive appointment reminders? (Circle one): Call Text Email

_____ _____
Social Security Number | Email Address

_____ _____
Employer | Employer Phone Number

Marital Status (Circle one): ☐Single ☐Married ☐Divorced ☐Widowed ☐Decline Sex (circle one): ☐Male ☐Female ☐Transgender

_____ _____
Spouse Name | Spouse Phone Number

Occupation: _____ Patient is a Student (Circle one): Full-Time Part-Time

Is your condition a work injury? Yes ____ No ____ Auto accident? Yes ____ No ____

Preferred Language: _____ Ethnicity: Hispanic or Latino _____ Non-Hispanic or Latino _____
Race: American Indian or Alaskan Native _____ Asian _____ Black/African American _____ White _____
Native Hawaiian or Pacific Islander _____

EMERGENCY CONTACT INFORMATION

_____ _____ _____
Contact Name | Contact Phone Number | Relationship to Patient

REFERRAL INFORMATION

_____ _____
Referring Physician | Referring Physician Phone Number

How did you hear about us? (Circle one): Family/Friend Physician Physical Therapist Internet Other

Patient name: _____

INSURANCE INFORMATION

Primary Insurance Information	Policy/Claim#	Group #	Effective date
Policy Holder's Name	Policy Holder Date of Birth		Relationship to Patient
Secondary Insurance Information	Policy/Claim#	Group #	Effective Date
Secondary Insurance Policy Holder's Name	Date of Birth		Relationship to Patient

WORKERS COMPENSATION INSURANCE

Insurance Company Name/Address	Claim Number	Phone/Name of Representatives

My signature shows that I attest to all of the information provided on these sheets are correct and filled out to the best of my knowledge and ability.

Signature of Patient: _____

(Patients must be 18 years or older to sign. Parent or guardian signature required if under 18 years or age)

Date: _____

Please DOWNLOAD and complete forms. Fax to (877) 287 - 3117. Email to frontdesk@gustavelorthopedics.com, or print in advance of your appointment. Forms will be signed at your appointment.

Patient name: _____

PATIENT HEALTH HISTORY

_____ _____ _____ _____
Legal First Name | Legal Last Name | Middle Initial | Maiden Name

_____/_____/_____ _____ _____ _____ Dominant Hand (Circle one): Right Left
Birth Date | Age | Height | Weight

_____
Preferred Pharmacy | Pharmacy Street or Address

Are you currently Pregnant? No _____ Yes _____ Are you currently Breastfeeding? No _____ Yes _____

PATIENT INTAKE HISTORY

Body part to be Examined: _____ (Circle one): Right Left Bilateral

_____ _____
Approximate Date of Symptom Onset or Injury. | Mechanism of Injury (if applicable).

Rate your pain on a scale of 1-10, with 10 being the worst. _____

What increases your pain? _____

What treatment have you tried? (Circle all that apply):

Rest Ice Heat Oral Medications Topical Medications NSAIDS Steroid Injections
Physical Therapy Home Exercises Wearing a Sling, Brace or Orthotics TENS Unit Chiropractic Care

How many weeks of Physical Therapy? _____

How many weeks of Home Exercises as directed by a Physician or Physical Therapist? _____

Steroid Injection Date:_____ How long did this injection give you pain relief for? _____

Other Treatment: _____

PAST SURGICAL HISTORY

Procedure Type | Surgeon | Date

_____
_____
_____
_____
_____
_____
_____
_____
_____

Any problems with Anesthesia? No _____ Yes _____

ALLERGIES

Name of Medication(s): _____
_____

(Circle all that apply ☐ Latex ☐ Sutures ☐ Tape/Adhesives ☐ Metal, Type of Metal: _____

Patient name: _____

CURRENT MEDICATIONS (Please include any over-the-counter medications, vitamins, etc.)

Name Strength How Often

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO
Asthma			Fibromyalgia			Sleep Apnea		
Atrial Fibrillation			Gallbladder problems, Stones, or disease			Seizure Disorder		
Bleeding Tendencies			Hepatitis A			Osteoporosis		
DVT or Blood Clots			Hepatitis B			Osteoarthritis		
Concussion			Hepatitis C			MRSA		
COPD			High Blood Pressure			Liver Problems or Jaundice		
Emphysema			HIV or AIDS			Kidney Disease		
Diabetes Type 1			Problems with Anesthesia					
Diabetes Type 2			Thyroid Disease					
Endocrine Disorder			Stomach Ulcer			Other, please list:		

FAMILY MEDICAL HISTORY

	HEART DISEASE	DIABETES	HYPERTENSION	MENTAL DISORDER	CANCER	OTHER
FATHER						
MOTHER						
GRANDPA/GRANDMA						

Patient name: _____

SOCIAL HISTORY

List Recreational Activities or Hobbies:

_____

_____

Tobacco Use? No _____ Yes _____ Pack per day: _____ For how long? _____ Quit Date: _____
Type (Circle all that apply): Chew Cigars Cigarettes Vape

Alcohol Use? No _____ Yes _____ Drinks per week: _____ Quit Date: _____

Recreational Drug Use? No _____ Yes _____ Frequency: _____ For how long? _____

REVIEW OF SYMPTOMS: CIRCLE ALL CURRENT SYMPTOMS

HEENT:	GI:	CV:	MUSCULOSKELETAL	HEMATOLOGY
Vision changes Hearing loss Sore throat Runny nose Sinus problems Ringing in ears Seasonal allergies	Vomiting Diarrhea Bloody stools Reflux Heartburn Nausea Inflammatory BD	Heart attack High blood pressure Heart murmur Chest pain	Joint pain Joint stiffness Swelling Catching or locking Gout	Anemia Blood clot Easy bleeding Easy bruising

ENDOCRINE	RESPIRATORY	URINARY	NEURO	
Osteoporosis Osteopenia Weight gain Weight loss Heat/cold intolerance	Cough Sleep apnea Wheezing Asthma Shortness of breath	Urgency Frequency Burning Pain urinating Difficulty urinating Bloody urine	Stroke or TIA Headaches Seizures Dizziness Numbness/Tingling Weakness Migraines	

List all of the above that apply (if filling form online):

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