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

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

_____/_____/_________ ________ ___________ _____________

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 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? __________________

PAST SURGICAL HISTORY

Procedure Type | Surgeon | Date

____
____
____
____
____
____
____
____
____

ALLERGIES

____
____

No Known Drug Allergies

(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						

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? _______

Dominant Hand (Circle one): Right Left

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

REVIEW OF SYMPTOMS: CIRCLE ALL CURRENT SYMPTOMS

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

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

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

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