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 HEALTH HISTORY

_____ _____ _____ _____

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

_____

Age

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? _____

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

Name	Strength	How Often

Patient name: _____

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:		

ALLERGIES

_____

_____

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

PAST SURGICAL HISTORY

Procedure Type Surgeon Date

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 Height _____ Weight _____

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

_____ _____

Preferred Pharmacy Pharmacy Street or Address