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 Preferred Name

____ _________ ____________________ _________ ________________
Billing Address Apt. # City State Zip

____ ____
Primary Phone number Additional Phone Number

____ ____
Social Security Number Email Address

____ ____
Employer Employer Phone Number

____
Preferred Pharmacy Pharmacy Street or Address

Marital Status (Check one): Single Married Divorced Widowed Decline Sex (check one): Male Female Transgender

Occupation: _____________________________________ Patient is a Student (Check 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? (Check 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

________________________ ___________________________

Preferred Name Maiden Name

_____/_____/_________ ________ ___________ _____________ Dominant Hand (Check one): Right Left

Birth Date Age Height Weight

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

PATIENT INTAKE HISTORY

Body part to be Examined: ____ (Check 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? (Check 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): ____

____

(Check 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			Endocrine Disorder			Thyroid Disease		
Atrial Fibrillation			Fibromyalgia			Stomach Ulcer		
Bleeding Tendencies			Gallbladder problems, Stones, or disease			Sleep Apnea		
DVT or Blood Clots			Hepatitis A			Seizure Disorder		
Concussion			Hepatitis B			Osteoporosis		
COPD			Hepatitis C			Osteoarthritis		
Glasses or Contacts			Hearing			MRSA		
Emphysema			High Blood Pressure			Liver Problems or Jaundice		
Diabetes Type 1			HIV or AIDS			Kidney Disease		
Diabetes Type 2			Problems with Anesthesia			Other, please list:		

FAMILY MEDICAL HISTORY

	HEART DISEASE	DIABETES	HYPERTENSION	MENTAL DISORDER	CANCER	OTHER
FATHER						
MOTHER						
SIBLING						
CHILD						
GRANDPARENT						

Patient name: ____

SOCIAL HISTORY

List Recreational Activities or Hobbies:

____

____

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

Alcohol Use? No _______ Yes _______ Type Drinks per week: _______ Quit Date: ________________
(Check all that apply): Beer Wine Liquor

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

Type: ____ Quit Date: ________________

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			

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

List all of the above that apply (if filling form on-line):

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