Please complete forms and fax to (877) 287-3117 or email to frontdesk@gustavelorthopedics.com in advance of your appointment.
Forms will be signed at your appointment.

DATE: ______________________________

REFERRED BY: ____________________________________
(MD/Coach/Trainer/Friend, etc.)

CURRENT SPORT: __________ TEAM/SCHOOL: __________

PATIENT: ____
(Last Name) (First Name) (M.I) (Preferred Name)

PATIENT ADDRESS: __________________________________ CITY: __________ STATE: _____ ZIP: _______

DOB: ___________ AGE: _____ SEX: M☐ F☐ SOCIAL SECURITY NUMBER: ___________________________

CELL PHONE: ________________ WORK PHONE: ________________ HOME PHONE: ________________

PATIENT EMPLOYER: ____

MARITAL STATUS: ____________________ PATIENT IS A STUDENT: Full-Time ☐ Part-Time ☐

HOW WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS? Cell Call☐ Cell Text☐ Email☐ Home Phone☐

PATIENT/GUARDIAN'S EMAIL ADDRESS: ____
(Email must belong to a patient if 18+ years of age or parent/guardian if minor)

ETHNICITY: Hispanic or Latino☐ Non-Hispanic or Latino☐ **PREFERRED LANGUAGE:**
____

RACE: American Indian **OR** Alaskan Native☐ Asian☐ Black/African American☐ White☐ Native Hawaiian **OR** Pacific Islander☐

Emergency Contact: Name: ________________ Relationship: _____________ Phone #: _________________

Is the patient the policyholder for insurance? Yes☐ No☐ If Yes, Insurance Company: ________________________

<u>Please Complete for Patient insurance, Dependent insurance, or other insured.</u>

Spouse☐ Father☐ Mother☐ Other☐ Name: ____

DOB: ______________ SSN: ________________________

Employer: ______________________________ Phone #: _______________ Work Phone: _______________

Home Address: ____ City: __________ State: _____ ZIP: _______
(Indicate if same as patient or please complete address line above)

____
(Insurance Company Name) (Policy ID#) (Group #)

<u>Please Complete for Workers Compensation insurance or Motor Vehicle insurance.</u>

____
(Insurance Company Name and Address) (Claim Number) (Phone and Name for Agent or Representatives)

SIGN HERE____**Date:**____________________

(***PATIENCE MUST BE 18 YEARS OR OLDER TO SIGN.*** *PARENT/GUARDIAN SIGNATURE REQUIRED UNDER 18 YEARS OF AGE*)

Date:

Patient's Name: ___________________________ Date of Birth: ___/___/______ Height: _______Weight: ______

Occupation: ____

Chief complaint/Reason for Visit: R L ____

Date of Injury: ____________________

How severe is the pain on a scale of 1-10, with 10 being the worst? ______

Type of pain (Put an X by all that apply): Sharp____ Dull____Pins/Needles_____Aching_____Cramping____

Throbbing____ Constant_____ Intermittent____

Who referred you to Gustavel Orthopedics? Name:____

Place an X by one: Physical Therapist____Physician____Physician Assistant____Friend/Family____

Please answer the following questions:

	Current every day user	Current some day user	Former user	Never user
Do you smoke?				
Do you drink alcohol?				
Do you use any recreational drugs?				

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		
Blood clots or DVT			Hepatitis			Seizure disorder		
Concussion			Hearing			Osteoporosis		
COPD			Hepatitis			Osteoarthritis		
Contacts/glasses			High blood pressure			MRSA		
Emphysema			HIV or AIDS			Liver problems or jaundice		
Diabetes type 1			Diabetes type 2			Kidney disease		

Past Surgical History:

Name: ____ Year: ______ Laterality: **R L Bilateral**

Name: ____ Year: ______ Laterality: **R L Bilateral**

Name: ____ Year: ______ Laterality: **R L Bilateral**

Name: ____ Year: ______ Laterality: **R L Bilateral**

Name: ____ Year: ______ Laterality: **R L Bilateral**

Name: ____ Year: ______ Laterality: **R L Bilateral**

Allergies:

	Please list allergy and reaction
Allergies to Medication	
Latex, Sutures, Tape, Metal, Jewelry	
Other:	

Medications you are taking

Medication Name	Strength	How many pills do you take at a time?	How often do you take these pills?

Pharmacy name and location: ____

My signature shows that I attest that all of the information provided on this sheet is correct and filled out to the best of my ability.

Signature of Patient: ____ Date: ___________

Signature of Patient's Representative: __________________________________ Date: __________

Relationship to Patient: _________________________

Review of Symptoms (place an X by all that apply)

***General*: None____**		
Overall Health____	Fever____	Sleep disturbance____
Change in appetite____	Headache____	Weight loss____
Chills____	Lightheadedness____	You or a family member has had a
Fatigue____	Night sweats____	problem w/anesthesia____

***Allergy/immunology/ENT:* None____**		
Itching____	*Respiratory*:	Cough____
Rash____	Asthma____	Shortness of breath____
Seasonal allergies____	Breathing problems____	Wheezing____
Nose/throat problems____	Chest pain____	

***Cardiovascular*: None____**		
Chest pain____	Irregular heartbeat____	Weight gain____
Heart problems____	Swelling in hands/feet____	
High blood pressure____	Weakness____	

***Skin:* None____**		
Hives____	Masses____	Rash on feet____
Itching____	Rash____	Skin cancer____

***Gastrointestinal/Genitourinary*: None____**		
Abdominal pain/swelling____	Vomiting____	Frequent urination____
Heartburn____	Weight loss____	Kidney problems____
Nausea____	Blood in urine____	Pain in lower back____
Stomach problems____	Difficulty urinating____	Painful urination____

***Musculoskeletal:* None____**		
Arthritis/arthralgia____	Joint stiffness____	Painful joints____
Back problems____	Leg cramps____	Sciatica____
Carpal tunnel____	Muscle aches____	Swollen joints____
History of gout____	Pain in shoulder(s)____	Weakness____

***Neurologic*: None____**		
Balance difficulty____	Loss of strength____	Paralysis____
Dizziness____	Loss of use of extremity____	Seizures____
Fainting____	Low back pain____	Stroke____
Gait abnormality____	Memory loss____	Tingling/numbness_____
Headache____	Pain____	