

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.



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: _____

Please Complete for Patient insurance, Dependent insurance, or other insured.

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 #)

Please Complete for Workers Compensation insurance or Motor Vehicle insurance.

(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 problem w/anesthesia _____
Fatigue _____	Night sweats _____	

Allergy/immunology/ENT: None _____		
Itching _____	<i>Respiratory:</i>	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 _____	