

PATIENT INFORMATION

Name _____ Social Security # _____
 Last First Middle

Birthdate _____ Age _____ Male Female Single Married Separated Divorced

Mailing Address _____
 Street City State Zip

Home Phone _____ Cell Phone _____

Email address _____ Employer _____ Occupation _____

Employer Address _____ Work Phone _____

Spouse/Parent Name _____ Work Phone _____

Spouse/Parent Employer _____

PRIMARY CARE PHYSICIAN:

REFERRED BY:

Reason for this visit: Illness Injury Job related injury Auto accident Other _____

Date of injury or onset of problem _____ Part of body injured _____ Right Left Both

How did this happen? _____

Worker's Compensation carrier _____ Claim # _____

Address _____ Claim Mgr Name & Number _____

If you were hospitalized for this: Where _____ When _____

PRIMARY Ins _____ SS# _____ Group # _____

Subscriber _____ Subscriber's Date of Birth _____ Relationship to subscriber
 self spouse child

Employer _____ Address _____ Work Phone _____

SECONDARY Ins _____ SS# _____ Group # _____

Subscriber _____ Subscriber's Date of Birth _____ Relationship to subscriber
 self spouse child

Employer _____ Address _____ Work Phone _____

In case of EMERGENCY: Relative to contact (other than spouse) _____ Phone _____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party _____ Address _____

Relationship to patient _____ Social Security # _____ Birthdate _____

I acknowledge that I am financially responsible for all charges. I hereby authorize my insurance benefits to be paid directly to my physician. I also authorize the doctor and/or insurance company to release any information required for this claim.

Note: **If the patient is under 18 years of age, the accompanying parent is responsible for all bills**

Signature _____

Date _____

Hip and Knee Intake

James D. Bruckner, MD

Please leave gray areas blank, provider will complete:

CC: _____
Onset: _____
Duration(ie. constant, intermittent, worsening, improving): _____
Location of pain (ie. along the medial joint line): _____
Description of pain(ie. sharp, dull): _____
Aggravating factors: _____ Relieving factors: _____
Prohibits (limitations due to condition): _____

Patient to complete information below:

Name _____	Age _____
Referring Physician _____	How did you hear about us? _____
Address _____	Phone _____
Primary Care Physician _____	
Address _____	Phone _____
Is this a work related problem? Yes No	If yes, list your OWCP or L&I # _____

Why are you being seen today?

Right Hip Left Hip Right Knee Left Knee Other (please indicate) _____

How far can you walk before needing to rest?

Indoors only Less than 1 block 2-3 blocks 4-6 blocks Not Limited

Do you need assistance with walking?

No assistance Cane Crutches Walker Wheelchair

How do you manage stairs?

Without difficulty Need banister Banister, one step at a time Can't do stairs

Can you sit in a chair?

Any chair, at least 1 hour Some chairs, ½ hour or less Can't sit

How do you arise from a chair?

Normally Need arm assistance Difficult, need both arms Need someone to help Unable

Can you reach your socks and shoes?

Easily With difficulty Unable

Please rate the intensity of your joint pain/discomfort when at rest:

(0= No pain, 10= Severe pain) (mark one)

0 1 2 3 4 5 6 7 8 9 10

Please rate the intensity of your joint pain/discomfort with activity or weight bearing:

(0= No pain, 10= Severe pain) (mark one)

0 1 2 3 4 5 6 7 8 9 10

Have you had any of the following treatments for your joint problem?			
Medications?	Yes	No	If yes, please list: _____
Injections?	Yes	No	If yes, please list: _____
Physical Therapy?	Yes	No	
Glucosamine/Chondroitin	Yes	No	
Other?	Yes	No	If yes, please list: _____

Allergies: (check box below to all that apply)	
<input type="checkbox"/> No known drug allergies	<input type="checkbox"/> Penicillin (PCN)
<input type="checkbox"/> Sulfa	<input type="checkbox"/> Other (please specify) _____

Past Medical History: Do you have, or are you being treated for, any of the following:

Allergies (allergic rhinitis) Anxiety Asthma Bipolar Bleeding/clotting disorder Cancer (CA) Chemical/Alcohol dependency Chronic lung disease/emphysema (COPD) Congestive heart failure (CHF) Coronary artery disease (CAD) Depression Diabetes (using insulin) (IDDM) Diabetes (no insulin)(NIDDM) Fibromyalgia	Heartburn/reflux (GERD) Heart attack (MI) Hepatitis ____ (please specify type) High blood pressure (HTN) High cholesterol Psoriasis Rheumatoid Arthritis (RA) Stomach ulcers/peptic ulcer disease (PUD) Stroke/transient ischemic attack (TIA) Thyroid disorder (please list) _____ Sleep disorder/trouble sleeping/(insomnia) Other (specify) _____ _____ _____
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Medications:	Dose:	Times per day:	Reason you are taking:
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			
7. _____			
8. _____			
9. _____			

Family History: (check box below to all that apply)

Arthritis Cancer Clotting disorder
Diabetes High Blood Pressure Rheumatoid
Other _____

Bone/joint surgeries: (Ortho)

<u>Procedure</u>	<u>Year</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries:

	<u>Year</u>
No previous surgeries	
Appendix (appendectomy)	_____
Gall bladder (cholecystectomy)	_____
By-pass/open heart (CABG)	_____
Hernia repair	_____
Hysterectomy	_____
Tonsils removed (tonsillectomy)	_____
Other surgeries:	
_____	_____
_____	_____
_____	_____
_____	_____

Social History:

Work status? **Employed (please list current occupation)** _____

Unemployed Disabled Student Retired

Marital status?

Single Married Divorced Separated Widowed Domestic partner

Do you have any children?

Yes No If so, how many? _____ children.

Do you smoke?

Yes No If yes, how much per day? _____ When did you start smoking? _____

Do you drink alcohol?

Yes No If yes, how much? _____ drinks per week.

Do you have stairs in your home?

Yes No If yes, how many? _____ into house. _____ into bedroom

Review of Systems: (please check)

	No	Yes	Comments
GENERAL (fever, nightsweats/chills)			
VISION (glasses/contacts, cataracts, glaucoma)			
EAR/NOSE/THROAT (sinus trouble, hearing loss)			
CARDIAC (chest pain)			
PULMONARY (shortness of breath, difficulty breathing)			
GASTROINTESTINAL (heartburn)			
MUSCULOSKELATAL (joint pain, muscle pain)			
GENITOURINARY (painful urinating)			
SKIN (non-healing wounds)			
NEUROLOGIC (seizures, numbness/tingling)			
PSYCHIATRIC (anxiety, depression)			
ENDOCRINE (frequent urination, excessive thirst)			
HEMATOLOGICAL (bleeding/clotting problems)			
ALLERGIC/IMMUNOLOGICAL (HIV/AIDS)			

Provider to fill out this page:

PE:

Vitals: height _____ weight _____ BMI _____

Appearance: _____

Gait: level slightly antalgic moderately antalgic severely antalgic

Limb alignment:

Right: Neutral Valgus Varus

Left: Neutral Valgus Varus

Lymphs:

Musculoskeletal:

Additional Hx notes:

Effusion:

Tenderness:

Limb-length difference

ROM

Ligamentous Stability

Special Tests:

Neuro:

Sensation

EHL motor strength:

DTRs _____/4 ankle knees

Pulses:

Skin:

Impression/Plan:

Authorization to Leave Personal Health Information By Alternate Means

Patient Name: _____ Date of Birth: _____

Patient Mailing Address: _____

(Please check all that apply)

May leave detailed message on voicemail at home # : _____

May leave detailed message on voicemail at work # : _____

May leave information with spouse (name) : _____

May leave information with other family member: _____

May leave detailed message on cellular phone # : _____

May leave detailed message at a different location # : _____

May send detailed message by email to: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Patient or legally authorized individual signature

Date

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practice** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

This area for staff notes (if any):

This form will be retained in your medical record