PATIENT INTAKE FORM

Patient's Name_____ _____ _____ Date 6/18/2025
First Last MI

Patient's Date of Birth Email_____

Address_____
Street City State Zip Code

Cell Phone # _____Other Phone #_____Gender: ☐ Female ☐ Male

Employed? ☐Full Time ☐Part Time ☐Not Employed ☐Retired ☐Out of work due to injury

Employer Name_____Occupation_____

Employer Address_____
Street City State Zip Code

Emergency Contact_____Relationship to Patient_____ Phone #_____

Referring Physician Name_____Phone #_____

For Patients under the age of 18:

Parent/Guardian Name_____ Birth Date_____
First Last

Address_____
Street City State Zip Code

Cell Phone #_____ Other Phone #_____

Primary Insurance_____Policy Holder Relationship to Patient_____

Policy Holder's Name_____ _____ _____ Birth Date_____
Last First MI

ID #_____Group #_____

Secondary Insurance_____Policy Holder Relationship to Patient_____

Policy Holder's Name_____ _____ _____ Birth Date_____
Last First MI

ID #_____Group #_____

If injury is due to a motor vehicle accident or is a work-related injury, please complete the following:

Date of Accident/Injury_____ ☐ Auto Accident ☐ Work Injury

Insurance Company_____

Insurance Company Address_____
Street City State Zip Code

Claim #_____Adjuster's Name_____Adjuster's Phone #_____

MEDICAL HISTORY FORM

PATIENT NAME: _____ DOB: _____ DATE: 6/18/2025
First Last MI

Area(s) for which you're receiving therapy_____

Date of Injury (if any)_____ Approximate Date of Onset (if no injury)_____

Check which apply to your current condition:

☐ Work related injury ☐ Recurrence of previous injury ☐ Injury related to falling
☐ Motor vehicle accident ☐ Injury related to lifting
☐ Cause unknown ☐ Athletic/recreational injury ☐ Other: _____

Have you had treatment for this area before? ☐Yes ☐ No If yes, date last treated_____

Describe type of treatment_____

Have you had surgery for this area? ☐ Yes ☐ No If yes, date of most recent surgery_____

Type of Surgery_____

List any diagnostic testing you have had for this area: ☐ X-ray ☐ MRI ☐ CT scan ☐ EMG

Past Surgical History (type and date):_____

List any allergies (latex, drug, etc.):_____

Are you pregnant? ☐Yes ☐No ☐ N/A If "Yes", please list your due date:_____

Do you have or have you ever had any of the following?

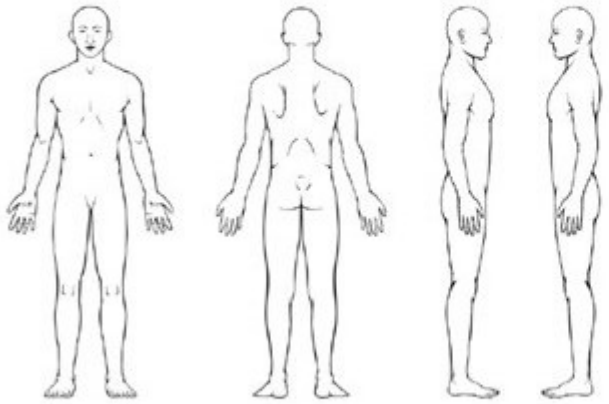
	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
High Blood Pressure	☐	☐	Allergies to Heat	☐	☐
Heart Disease	☐	☐	Allergies/Poor Tolerance to Cold	☐	☐
Heart Attack	☐	☐	Other Allergies	☐	☐
Heart Palpitations	☐	☐	Hernia	☐	☐
Pacemaker	☐	☐	Seizures	☐	☐
Headaches	☐	☐	Metal Implants	☐	☐
Kidney Problems	☐	☐	Dizziness/Fainting	☐	☐
Cancer	☐	☐	Recent Fractures	☐	☐
Osteoporosis	☐	☐	Skin Abnormalities	☐	☐
Bowel/Bladder Abnormalities	☐	☐	Nausea/Vomiting	☐	☐
Urine leakage	☐	☐	Ringing in your ears	☐	☐
Asthma/Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver/Gall bladder problems	☐	☐	Stroke/CVA	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Other:_____	☐	☐	Depression/Anxiety	☐	☐

Any other conditions not listed above_____

PATIENT NAME: _____ DOB: _____ DATE: 6/18/2025

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition

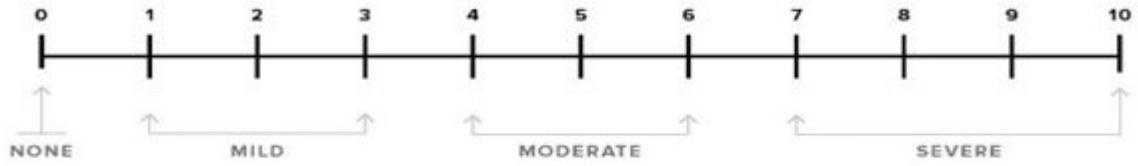


Key

↑ or ↓ Radiating Pain
XXX Spasm
ZZZ Tenderness
//// Numbness/Tingling
000 Ache/Pain

Please rate your pain number using the scale below: At this moment_____ At its best_____ At its worst_____

0-10 NUMERIC PAIN RATING SCALE



Please circle any symptoms you are currently experiencing:

Unexplained weight loss	Numbness/tingling	Changes in appetite	Fevers/chills/sweats
Depression	Shortness of breath	Dizziness	Headaches
Changes in bowel/bladder	Nausea/Vomiting	Poor balance/falls	Increased pain at night

Are your symptoms currently (circle one): Getting better / About the same / Getting worse

What are your personal goals for therapy at this time:_____

_____

To the best of my knowledge, the above information is true and correct.

Patient or Patient Representative's Signature:_____ Date:_____

PATIENT NAME: _____ DOB: _____ DATE: 6/18/2025
First Last MI

Consent for Treatment

I hereby authorize The Centers for Advanced Orthopaedics, through its appropriate therapy personnel, to perform an evaluation and treatment procedures, deemed necessary by the therapist, on me or the above named patient. This also authorizes, fabrication of a hand/upper extremity splint and serves as proof of receipt of such splint, if applicable, for myself or the above named patient.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or, if authorized by patient.)

Authorization to Release Information

I hereby authorize The Centers for Advanced Orthopaedics, to release to appropriate agencies, any information acquired in the course of my, or the above named patient's evaluation and treatment, necessary to process claims and pay The Centers for Advanced Orthopaedics directly for professional services rendered.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or, if authorized by patient.)

Late Cancellation/No-Show Policy

I understand that 24 business hours' notice is required for cancellation of an appointment. If I fail to cancel within 24 business hours' and/or do not show up for my appointment, The Centers for Advanced Orthopaedics may charge $35 to be paid by me, not my insurance company.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or, if authorized by patient.)

Acknowledgement of Receipt of Privacy Notice (HIPAA)

I acknowledge that I received or was offered the Notice of Privacy Practices for The Centers for Advanced Orthopaedics.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or, if authorized by patient.)

MEDICATION QUESTIONNAIRE

PATIENT NAME: _____DOB: _____DATE: 6/18/2025

Do you take any prescription and/or over the counter medications? ☐ Yes ☐ No

If you do take any prescription and/or over the counter medication, please list each medication below:

Medication Name	Type of Medication (Over the counter or Prescription)	Dosage (# of milligrams/ ounces)	Frequency (How many times per day or per week)	Route of Administration (oral, injection or topical)