NAME: _____ DATE: _____

What is your age? _____

What is your main complaint today?_____Right *or* Left side?

How long have you had this problem? _____

How did the problem start? _____

Is the problem related to work? _____

What kind of work do you do? Is it: (circle one) Light Medium Heavy

On a scale from 1-10 (10 being unbearable), how severe is your pain?(circle one) 1 2 3 4 5 6 7 8 9 10

Other Symptoms/Complaints:

☐ Weakness ☐ Instability ☐ Lock / Catch ☐ Discoloration ☐ Swelling
☐ Numbness ☐ Clicking ☐ Limited Motion ☐ Popping ☐ Grinding

How would you describe it?

☐ Aching ☐ Sharp ☐ Burning ☐ Dull ☐ Constant ☐ Intermittent

What sports or recreation do you participate in? _____

What school or team do you play for? _____

Did you receive treatment elsewhere? ☐ No ☐ Yes: (where)_____ (when): _____

Did you bring x-rays with you today? ☐ No ☐ Yes

Are you taking any medication for this? _____

Are you diabetic? ☐ YES ☐ NO List **Allergies**: _____

I agree that all the information stated above is true and accurate to the best of my knowledge:

_____ _____
Signature **Date**

How were you referred to our office today?

Physician (specify who) _____
I'm a Previous Patient _____
Insurance Provider (which one?) _____
Zoc Doc _____
Google (what did you search?) _____
Family Member (what's their name?) _____
Genesis website _____
Emergency Room (which one?) _____

Social Media (what platform?) _____
School (what's the school name?) _____
Urgent Care (which one?) _____
Radio (what station?) _____
Friend (what's their name?) _____
TV Ad (what station?) _____

EMAIL ADDRESS: _____

Patient Name: _____ SSN: _____

Patient Street Address:_____

City:_____ State:_____ Zip Code:_____

Home:_____ Work: _____ Cell: _____

Patient Date of Birth: _____ State Born In: _____

Marital Status: ☐S ☐M ☐D ☐W Spouse Name: _____

Patient Employer: _____ Occupation: _____ ☐FT ☐PT

Employer Address:_____

Emergency Contact Name: _____ Phone #: _____

Person responsible for bill (if different than Subscriber)**:** _____

We need your permission to release information about your condition, treatment or test results. Please indicate to whom we may communicate with and their relationship to you: _____

_____

_____

If someone *other than patient* holds the health insurance, please fill in the information below:

SUBSCRIBER Name:_____Relationship:_____
Address:_____
City: _____ State: _____ Zip Code: _____
Home: _____ Work:_____ Cell: _____
S.S.#: _____ Date of Birth: _____
Employer: _____ Occupation:_____ ☐FT ☐PT
Address: _____ City: _____ State: ___ Zip:_____

PRIMARY INSURANCE – We will take copy of card

Insurance Name: _____ Subscriber Name: _____
Policy #: _____ Group #: _____

SECONDARY INSURANCE – We will take copy of card

Insurance Name: _____ Subscriber Name: _____
Policy #: _____ Group #: _____

Signature below indicates the person ultimately responsible for any balance that may be incurred in the course of treatment of the patient. In addition, this authorizes Genesis Orthopedics & Sports Medicine to release any information necessary for the collection of any charges incurred by the patient.

_____ _____

SIGNATURE *DATE*

GENESIS ORTHOPEDICS & SPORTS MEDICINE

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Preferred Language: _____

PHARMACY PREFERENCE

Local Pharmacy Name: _____ Town: _____ Street: _____

PATIENT'S MEDICAL HISTORY (yes or no)

	Y	N		Y	N		Y	N		Y	N
Alcohol/Drug Abuse	☐	☐	Cataract	☐	☐	Heart Attack	☐	☐	Nerve/Muscle Disease	☐	☐
Allergies (other than meds)	☐	☐	Circulation Problems	☐	☐	Heartburn/GERD/Ulcers	☐	☐	Osteoporosis	☐	☐
Anemia	☐	☐	Colitis/Bowel Disease	☐	☐	High Blood Pressure	☐	☐	Pneumonia	☐	☐
Anxiety	☐	☐	Congestive Heart Failure	☐	☐	HIV/AIDS	☐	☐	Seizures	☐	☐
Arthritis	☐	☐	Chronic Obstructive Pulmonary Disease	☐	☐	Jaundice	☐	☐	Sickle Cell	☐	☐
Asthma	☐	☐	Depression	☐	☐	Kidney Disease	☐	☐	Stroke	☐	☐
Birth Defect/Genetic Problem	☐	☐	Diabetes	☐	☐	Meningitis	☐	☐	Thyroid Disease		
Blood Clots	☐	☐	Emphysema	☐	☐	Mental Health Problems	☐	☐	Tuberculosis		
Blood Transfusion	☐	☐	Glaucoma	☐	☐	Murmur	☐	☐	Viral Hepatitis		
Cancer	☐	☐	High Cholesterol	☐	☐	ADD/ADHD	☐	☐	Foot Problems?		
Other Medical History:											

PATIENT'S SURGICAL HISTORY (yes or no)

	Y	N		Y	N		Y	N		Y	N
Abdomen Surgery	☐	☐	Brain Surgery	☐	☐	C-Section	☐	☐	Hernia Repair	☐	☐
Appendectomy	☐	☐	Breast Surgery	☐	☐	Cholecystectomy (Gallbladder)	☐	☐	Hysterectomy	☐	☐
Surgical Repair: Broken Bones/Fractures	☐	☐	Colon Surgery	☐	☐	Adnoid/Tonsillectomy	☐	☐	Joint Replacement	☐	☐
Coronary Artery Bypass Graft	☐	☐	Cosmetic Surgery	☐	☐	Sterilization	☐	☐	Ear Tubes	☐	☐
Other Surgical History:											

PATIENT's SOCIAL HISTORY for 1O YRS OLD and UP

Tobacco Use	☐ Yes ☐ NEVER ☐ Quit ☐ Passive	Comment_____
Packs/Day	☐ .25 ☐ .5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 3	Years of Smoking _____
Quit Date		
Alcohol Use	☐ Y ☐ N	
Drinks/Week	Glass(es) of Wine	Comment_____
	Can(s) of Beer	
	Shot(s) of Liquor	
	Drinks containing O.5 oz of alcohol	
Internal Drug Use	☐ Y ☐ N	Comment_____
Per Week		Types: Marijuana ☐ Methamphetamines ☐ Cocaine ☐ IV ☐

OVER →

Please complete the form below relating to your family's medical history.

PLACE AN "X" IN THE APPROPRIATE BOX BELOW (see example)

PATIENT'S FAMILY HISTORY

Relationship		Name	Deceased	Cancer: Type and age of death (if applicable)	Diabetes-Type	Heart Failure	Hypertension (High Blood Pressure)	Asthma	High Cholesterol	Arthritis-Rheumatoid	Arthritis-Osteo	Stroke	Thyroid Disease	Seizures	Migraines	Rashes/Skin Problems	Other _____
Example	**Sister**	**Sally**			X			X				X					
Parents	Mother																
Parents	Father																
Siblings																	
Siblings																	
Siblings																	
Siblings																	
Siblings																	
Children																	
Children																	
Children																	
Children																	
Grandparents	[1]MGM																
Grandparents	[1]MGF																
Grandparents	[2]PGM																
Grandparents	[2]PGF																

1: Maternal
2: Paternal

Current Medications: _____

_____

Allergies: _____

_____

Do you see other physicians? Yes No

Name _____ For what? _____

Name _____ For what? _____

Name _____ For what? _____

Name _____ For what? _____