

TODAY'S DATE:

**PATIENT INTAKE SHEET**

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ Age: \_\_\_\_\_  
SEX: . ARE YOU RIGHT OR LEFT HANDED? (**CIRCLE**) RIGHT LEFT HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ ARE YOU WORKING NOW? (**CIRCLE**) YES NO

IF NO, WHEN DID YOU LAST WORK? \_\_\_\_\_

PRIMARY CARE (FAMILY) PHYSICIAN: \_\_\_\_\_

ARE YOU UNDER THE CARE OF ANY SPECIALISTS (**PLEASE LIST**): \_\_\_\_\_

WERE YOU REFERRED BY A PHYSICIAN? YES/ NO WHO? \_\_\_\_\_

**CURRENT PHARMACY (LOCATION):** \_\_\_\_\_

**CHIEF COMPLAINT:**  
WHAT ARE YOU HERE FOR? \_\_\_\_\_

PLEASE RATE YOUR PAIN ON A SCALE OF 1-10 (1-MILD, 10-UNBEARABLE) \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

WHEN DID THE PROBLEM START? \_\_\_\_\_ HOW DID IT START? (IE: .INJURY, SLOWLY) \_\_\_\_\_

IF INJURY:

WAS IT RELATED TO A WORK ACCIDENT? YES NO

WAS IT RELATED TO A MOTOR VEHICLE ACCIDENT YES NO

DATE OF INJURY: \_\_\_\_\_

HAVE YOU HAD ANY TREATMENT FOR IT? (**CIRCLE**) YES NO.

MEDICATIONS TAKEN \_\_\_\_\_

PHYSICAL THERAPY? YES NO FOR \_\_\_\_ WEEKS. CORTISONE INJECTIONS? YES NO # OF INJECTIONS \_\_\_\_

HAVE YOU HAD ANY TESTS FOR THIS PROBLEM? YES NO

IF YES CIRCLE ALL THAT APPLY: X RAYS, CAT SCAN, MRI, NERVE STUDIES, BLOOD STUDIES

**PAST MEDICAL HISTORY: DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE)**

DIABETES	THYROID DISEASE	HIGH BLOOD PRESSURE	ASTHMA	STROKE
ARTHRITIS	ULCERS	GOUT	BLEEDING TENDENCY	BLOOD CLOT
LIVER DISEASE	HEARING IMPAIRED	HEART DISEASE	KIDNEY DISEASE	

CANCER: IF CIRCLED, PLEASE DESCRIBE: \_\_\_\_\_

**PAST SURGICAL HISTORY: HAVE YOU HAD ANY SURGERY (OPERATIONS) AT ANY AGE? YES NO**

IF YES PLEASE LIST WITH DATE: \_\_\_\_\_

**MEDICATIONS: ARE YOU CURRENTLY TAKING ANY MEDICATIONS OR HERBAL SUPPLEMENTS? (INCLUDE OVER THE COUNTER) YES NO IF YES PLEASE LIST:**

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY
1. _____			5. _____		
2. _____			6. _____		
3. _____			7. _____		
4. _____			8. _____		

\_\_\_\_\_  
M.D. SIGNATURE

\_\_\_\_\_  
DATE

**ALLERGIES:** ARE YOU ALLERGIC TO ANY MEDICATIONS? (**CIRCLE**) YES NO. IF YES, WHAT REACTION TO WHAT MEDICATION DID YOU HAVE?

MEDICATION

REACTION

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**ARE YOU ALLERGIC TO LATEX (RUBBER PRODUCTS)? (CIRCLE) YES NO**

**HAVE YOU EVER HAD AN INFECTION THAT WAS RESISTANT TO ANTIBIOTICS? SUCH AS MRSA? YES NO**

**SOCIAL HISTORY:**

DO YOU SMOKE? YES NO IF YES HOW MUCH? \_\_\_\_\_ PACKS PER DAY  
DO YOU DRINK ALCOHOL YES NO IF YES HOW MUCH? \_\_\_\_\_ PER DAY/WEEK  
DO YOU TAKE ADDICTIVE DRUGS YES NO IF YES WHAT \_\_\_\_\_

**FAMILY HISTORY:** DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING. PLEASE CIRCLE ALL THAT APPLY:

DIABETES SICKLE CELL GOUT HEART DISEASE BLOOD CLOT  
CANCER ARTHRITIS HIGH BLOOD PRESSURE BLEEDING DISORDERS

OTHER KNOWN FAMILY DISEASE: \_\_\_\_\_

IS YOUR MOTHER ALIVE YES: AGE: \_\_\_\_\_ NO: AGE AT DEATH: \_\_\_\_\_

IS YOUR FATHER ALIVE YES: AGE: \_\_\_\_\_ NO: AGE AT DEATH: \_\_\_\_\_

**REVIEW OF SYSTEMS: DO YOU HAVE ANY OF THE FOLLOWING. PLEASE CIRCLE ALL THAT APPLY**

*CONSTITUTIONAL SYMPTOMS:* FEVER, WEIGHT CHANGE (INCREASE, DECREASE) # OF LBS \_\_\_\_ IN \_\_\_\_ MONTHS,  
FATIGUE, APPETITE CHANGE (INCREASE, DECREASE)

*EYES:* DOUBLE VISION, BLURRING, TRAUMA, GLASSES

*ENT & MOUTH:* DEAFNESS, SINUSITIS, RINGING IN EARS, DIZZINESS

*CARDIOVASCULAR:* CHEST PAIN, PALPITATIONS, CALF PAIN WHILE WALKING (CLAUDICATION),  
IRREGULAR HEART BEATS

*RESPIRATORY:* SHORTNESS OF BREATH, WHEEZING, COUGH, COUGHING BLOOD

*GI:* DIARRHEA, CONSTIPATION, ABDOMINAL PAIN, VOMITING, BLOODY STOOL

*GU:* HESITANCY, INCONTINENCE, PAIN ON URINATION, FREQUENT URINATION, MENSTRUAL PROBLEMS,  
PREGNANCY

*MS:* OLD FRACTURE, SPRAINS, JOINT PAIN, JOINT SWELLING, ARTHRITIS, STIFFNESS, ATROPHY

*SKIN:* CHANGE IN COLOR OR TEMPERATURE, RASHES, LESIONS, SCARS, MASSES, ULCERS, DERMATITIS,  
ECZEMA

*NEURO:* PROBLEMS WITH SPEECH OR SWALLOWING, STROKE, CHANGES IN SENSATION, SEIZURES, WEAKNESS,  
VISUAL CHANGES, BALANCE, MEMORY, IN COORDINATION PROBLEMS, NUMBNESS TINGLING IN  
EXTREMITIES

*PSYCH:* DEPRESSION, MOOD CHANGES, HALLUCINATIONS, SLEEP DISTURBANCES

*ENDOCRINE:* EXCESSIVE THIRST, HYPER/HYPOACTIVITY, GROWTH/HAIR CHANGES

*HEMATOLOGIC/LYMPHATIC:* BLEEDING TENDENCY, LYMPH NODE PAIN/ENLARGEMENT, ANEMIA



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# Northeast Orthopaedics, LLP

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_ acknowledge that I have received a copy of the Northeast Orthopaedics' Notice of Privacy Practices.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
date

Patient refused to sign after being offered the opportunity to do so.

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
date

*Note: This page is to be included in the patient's chart.*



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# Northeast Orthopaedics, LLP

## FINANCIAL DISCLOSURE

### Assignment and Release

I hereby authorize my insurance Benefits to be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I also authorize the physician to release any information required.

I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Statement to authorize payment of MEDICARE benefits

I certify that the information given by me in applying for payment under Title XVIII of the social security act is correct. I authorize any holder of medical information about me to release to the social security administration or its carriers, any information required to process my Medicare Claims. I request that payment under the medical insurance program be made to NORTHEAST ORTHOPAEDICS,LLP for services provided to me.

Beneficiary Signature: \_\_\_\_\_ Date: \_\_\_\_\_