

THE ORTHOPEDIC GROUP, INC.

INTAKE FORM

Welcome to our office. To help us better evaluate your condition, please complete the following form. If you have any questions, we will be happy to help you. Thank you

D.O.B. _____

Name: _____ Occupation: _____

Primary Care Doctor: _____ Referred By: _____

List all medications with dose, to include: Prescription, Over-the-Counter, Herbal, Nutritional Supplements:

Med: _____	Dose: _____	Med: _____	Dose: _____
Med: _____	Dose: _____	Med: _____	Dose: _____
Med: _____	Dose: _____	Med: _____	Dose: _____
Med: _____	Dose: _____	Med: _____	Dose: _____
Med: _____	Dose: _____	Med: _____	Dose: _____

See attached Sheet

DO YOU HAVE ANY DRUG ALLERGIES? YES NO DRUG(S): _____

List **all surgeries** you have had: _____

LOCATION OF PAIN OR INJURY: _____

DATE INJURED OR NOTICED PAIN: _____

PAST MEDICAL HISTORY (Please check any illnesses that you have been treated for: Items not checked are understood to be negative)

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Phlebitis | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Clot | |
| <input type="checkbox"/> Previous Back/Neck Injury | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy/Seizure | |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever | | |

Height: _____ Weight: _____ Age: _____ Marital Status: S M W D

Do/did you smoke tobacco? Yes No How many packs a day? _____ How many years? _____

Do/did you drink alcohol? Yes No Frequency? _____

Have you ever used or been dependent on drugs? Yes No Type? _____

FAMILY HISTORY (Please check any conditions your family members have: Items not checked are understood to be negative)

- | | | | | | |
|--|---|---|---|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Bleeding Ulcer | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Crohns Disease | | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Disease | | <input type="checkbox"/> NONE |

HAVE YOU HAD ANY RECENT EPISODES OF: (Please check: Items not checked are understood to be negative)

- | | | | | |
|--|---|--|---------------------------------------|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Swelling | <input type="checkbox"/> Visual Changes |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Rashes | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Frequent Infection |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Anxiety | <input type="checkbox"/> NONE |

Patient Signature _____ **Date** _____

OGI USE ONLY: Reviewed by _____ **Date** _____