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Returning Patient Forms (Check List)

Please make sure you have completed ALL of the following forms and remember to bring them to your first appointment.

- ☐ 1. Patient Registration
- ☐ 2. Orthopaedic History (2 pages)
- ☐ 3. Patient Pain (2 pages)

LOS ALAMITOS ORTHOPAEDIC MEDICAL & SURGICAL GROUP

PATIENT REGISTRATION

Patient Name: ____
Last | First | Middle Initial | Nickname

Home Address: ____
Street | Apt#

____
City | State | Zip

Home Phone: ____________________ Cell Phone: ____________________

Email: ____

Emergency Contact: ____________________ Emergency Phone: ____________________

Gender: ☐ Male ☐ Female Body part evaluated: ____________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/er

Birthdate: ____________ Age: ____________ Social Security#: ____________

Primary Care Physician: ____

Referred by (doctor/patient/friend): ____

Patient's Employer/School: ____

BILLING INFORMATION:

Primary Insurance:	**Secondary Insurance:**
Ins. Co. Name:	Ins. Co. Name:
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:
Policy #:	Policy #:
Group#:	Group#:
Employer:	Employer:

Does your insurance carrier require a referral? ☐ Yes ☐ No

Is this a labor or industrial claim? ☐ Yes ☐ No

INSURANCE PAYMENT AUTHORIZATION:

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished to me by any of the physicians at Los Alamitos Orthopaedic Medical and Surgical Group. I authorize any holder of medical information about me to release to my insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, and I accept financial responsibility for non-covered services.

____
Signature | Date

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ORTHOPAEDIC HISTORY

Please take a few minutes to complete this form. By doing so you will help your physician to provide the best medical care possible.

Thank you.

NAME: **AGE:** **DATE:**

Location of problem? Onset Date:

If injury, describe briefly:

Any previous surgery at problem site? Date:

Have you been hospitalized for your pain problem?

Have you been hospitalized for other medical problems?

WHAT ARE YOUR MAIN COMPLAINTS?

☐ Head ☐ Pain ☐ Neck ☐ Spasms ☐ Stiffness

DOES PAIN RADIATE TO YOUR UPPER EXTREMITIES?

☐ Yes ☐ No

☐ Shoulders ☐ Traps ☐ Right ☐ Left ☐ Both

☐ Elbows: ☐ Right ☐ Left ☐ Both

☐ Wrists: ☐ Right ☐ Left ☐ Both

☐ Fingers (which)? __________

DOES PAIN RADIATE TO YOUR LOWER EXTREMITIES?

☐ Yes ☐ No

☐ Hips: ☐ Right ☐ Left ☐ Both

☐ Knees: ☐ Right ☐ Left ☐ Both

☐ Ankles: ☐ Right ☐ Left ☐ Both

☐ Feet: ☐ Right ☐ Left ☐ Both

SYMPTOMS/COMPLAINTS:

Stiffness:	☐ none	☐ occasional	☐ frequent	
Numbness/tingling	☐ Yes	☐ No	☐ Where	
Swelling	☐ none	☐ occasional	☐ frequent	☐ constant
Weakness	☐ Yes	☐ No	☐ Where	
Limited/painful motion	☐ Yes	☐ No		
Grinding/Grating	☐ none	☐ occasional	☐ frequent	
Night Pain	☐ Yes	☐ No		
Giving Way/Buckling	☐ none	☐ occasional	☐ frequent	
Locking:	☐ none	☐ occasional	☐ frequent	
Bowel/Bladder Incontinence	☐ Yes	☐ No		

When (roughly what date) did your present pain start? __________

How long have you had this pain? ☐ Years ☐ Months ☐ Weeks

HOW DID YOUR PAIN START?

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Twisting ☐ Fall ☐ Bending ☐ Pulling ☐ Injured at work ☐ Injured in auto accident
☐ Hit from behind ☐ Injured during sports ☐ No apparent cause

Did you feel/hear a pop or tear? ☐ Yes ☐ No ☐ Unsure
Did your joint pop out? ☐ Yes ☐ No ☐ Unsure
Did you have weakness? ☐ Yes ☐ No ☐ Unsure
Did you continue activity? ☐ Yes ☐ No ☐ Unsure
Did it feel loose/unstable? ☐ Yes ☐ No ☐ Unsure

WHAT ACTIVITY MAKES THE PAIN WORSE?

☐ Exercise (during) ☐ Exercise (after) ☐ Sitting ☐ Standing ☐ Walking
☐ Bending Forward ☐ Bending backwards ☐ Coughing ☐ Sneezing

WHAT REDUCES THE PAIN?

☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Manipulation
☐ Physical Therapy exercise ☐ Pain pills ☐ Injections for pain
☐ Muscle relaxant pills ☐ Anti-inflammatory pills ☐ Nothing ☐ Other

PRIOR TREATMENT:

Did you see a physician? ☐ Yes ☐ No Dr. Name: ____________________

Have you had any of these diagnostic studies?

☐ X-rays: ☐ Yes ☐ No Date: ____________
☐ CT Scan: ☐ Yes ☐ No Date: ____________
☐ Myelogram: ☐ Yes ☐ No Date: ____________
☐ EMG / Nerve Conduction: ☐ Yes ☐ No Date: ____________
☐ Discogram: ☐ Yes ☐ No Date: ____________
☐ MRI: ☐ Yes ☐ No Date: ____________
☐ Arthrogram or sonogram: ☐ Yes ☐ No Date: ____________
☐ Injections: ☐ Yes ☐ No Date: ____________
☐ Medication prescribed? ☐ Yes ☐ No Rx Name: ____________
☐ Physical Therapy? ☐ Yes ☐ No
☐ Other treatment? ____________________

PRESENT OVERALL FUNCTION:

How far can you walk? Blocks ____________ Miles ____________
Can you climb stairs? ☐ Yes ☐ No ☐ without assistance ☐ with assistance
What is your present occupation? ____________________
Are you currently working? ☐ Yes ☐ No (if No) date last worked ____________

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PATIENT PAI

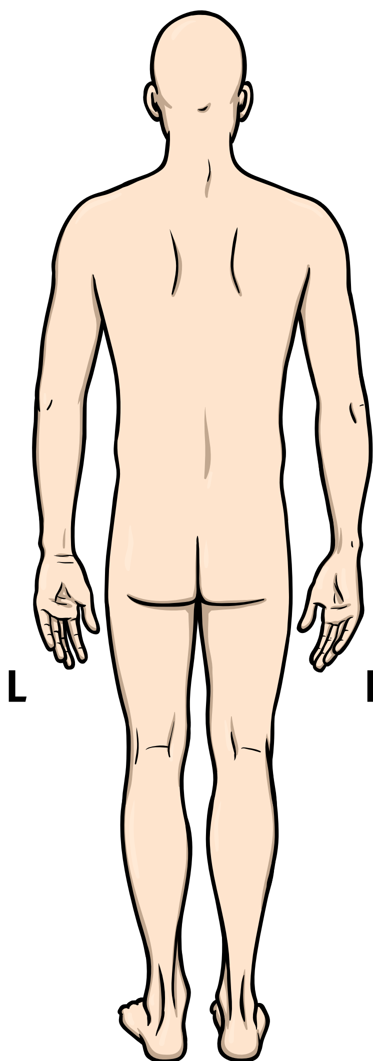
Patient Name *(Hombre)***:** **Date** *(Fecha)***:**

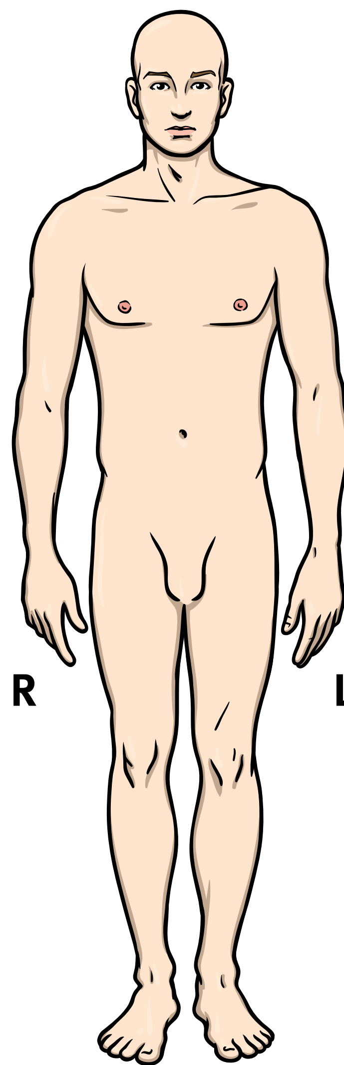
Mark the area on your body where you feel the described sensations.

Numbness	**Tingling**	**Burning**	**Stabbing**	**Aching**	**Cramping**	**Sensitive**	**Other**
0000	tttt	xxxx	////	====	cccc	ssss	pppp

Marke el area en su cuerpo donde usted siente Ias sensaciones descriptas.

Adormecido	*Hormiguero*	*Quemando*	*Cuchillada*	*Adolorido*	*Calambre*	*Sencible*	*Otro*
0000	tttt	xxxx	////	====	cccc	ssss	pppp





Signature (*Firma*)**:** **Date** (*Fecha*)**:**

PAIN RATING SCALES *(Escalas para medir dolor)*

Patient name ***(Hombre):*** ______________________ **Date** ***(Fecha):*** __________

Here is a thermometer with ***various*** grades of pain from ***"no pain at all"*** at the bottom to the ***"pain is almost unbearable"*** at the top. We want you to put a check by the phrase that describes your pain best. Please rate your pain over the last month.
(Favor de indicar cuanto fue su dolor la semana pasada)

- ☐ Pain is almost unbearable *(Dolores intolerable)*
- ☐ Very bad pain *(Dolor muy fuerte)*
- ☐ Quite bad pain *(Dolor fuerte)*
- ☐ Moderate pain *(Dolor en cantidad moderada)*
- ☐ Little pain *(Muy poco dolor)*
- ☐ No pain at all *(Sin dolor alguno)*

Please rate your highest level of pain last week. ***(Favor de indicar manta fue su dolor la semana pasada)***

1 2 3 4 5 6 7 8 9 10

No pain *(No dolor)* — Worst possible pain *(El peor posible)*

Signature (***Firma***)**:** ______________________ **Date** (***Fecha***)**:** __________