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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)

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a labor or industrial claim? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

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 _____

Patient Name (*Hombre*):

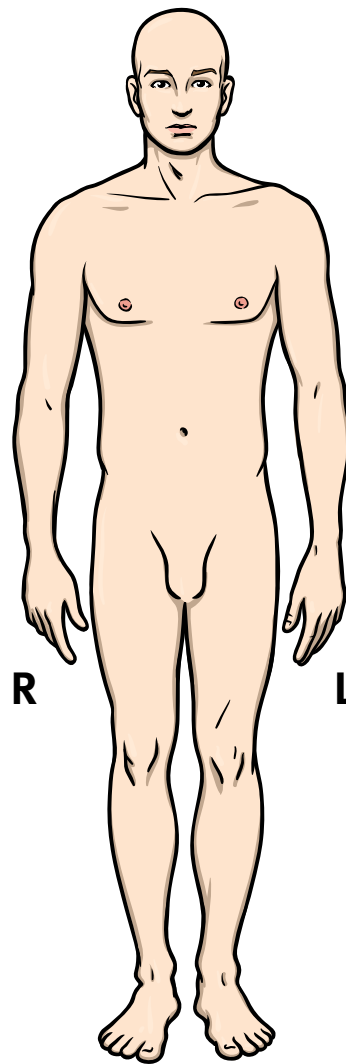
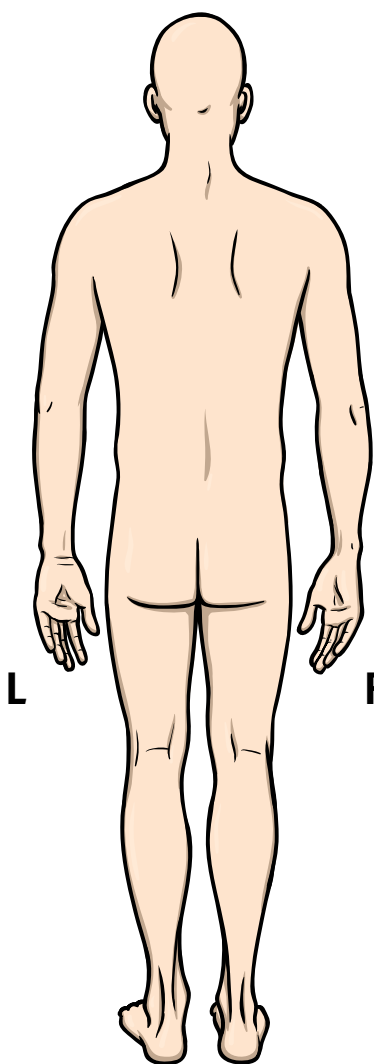
Date (*Fecha*):

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 las sensaciones descritas.

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 (<i>No dolor</i>)					Worst possible pain (<i>El peor posible</i>)				

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