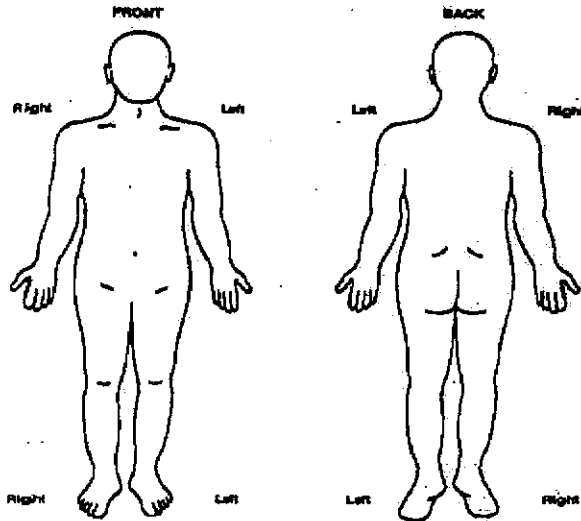


Mark the areas where you feel the above pain or sensation



NEW PROBLEM

Patient Name: _____

DOB: _____ Date _____

What is your pain level? On a scale from 0-10

0 _____ 5 _____ 10

Did another doctor send you to this office for evaluation?

Yes No Dr. _____

1. I am being seen for my: Right Left Bilateral (both)
- Shoulder Arm Elbow Forearm Wrist Hand Finger Neck Hip Thigh Knee
- Leg Ankle Foot Toe Back

2. Symptoms radiate to my: Right Left Shoulder Arm Hand
- Fingers Hip Thigh Leg Foot Toes

3. Are your symptoms a result of an injury? Yes No Date of injury: _____
- Is the injury work related? Yes No If yes, type of work: _____

Give an approximate time when your symptoms began: _____

Briefly describe the injury and/or development of your symptoms: _____

4. Did you seek medical treatment prior to this visit? Yes No
- If so, where: Emergency Room Urgent Care Physician's office Other

Name of Physician and/or facility who treated you: _____

What kind of treatment was given to you? Physical Therapy Injections

What medication was given?

Narcotic (vicodin) Anti-Inflammatory (Advil) Muscle Relaxers (soma) Steroids (prednisone)

Have you had any studies of the involved area within the past year?

X-rays MRI CT Scan other _____

Have you had surgery on this body part? Yes No Describe: _____

5. Have you had symptoms or an injury to this area before? Yes No Describe _____

6. Does the pain keep you up at night? Yes No

7. How far can you walk (in miles or blocks)? _____

Returning Patient Medication Update

Medication	Dosage	How often do you take?



Patient Demographic

Ventura Orthopedics

Account # :

Last Name		First Name		MI:
Address:				
Home Phone : leave msg		<input type="checkbox"/> OK to	Cell Phone: leave msg	
			<input type="checkbox"/> OK to	
Work Phone: leave msg		<input type="checkbox"/> OK to	Email :	
Family Physician (PCP):		Referring Provider:		
DOB:	Marital Status:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Social Security:
Employer:		Employer Address:		
Emergency Contact:		Relationship:		Contact Phone:

IF PATIENT IS A MINOR

Student Status: Full Time Part Time

Father's Name:		Mother's Name:	
Work Phone:		Work Phone:	
Employer:		Employer:	
Email:		Email:	

INSURANCE INFORMATION

Primary Insurance:		Secondary Insurance:	
Subscriber:		Subscriber:	
Birth date:		Birth date:	
Subscriber Relationship to Patient:		Subscriber Relationship to Patient:	
Subscriber Employer:		Subscriber Employer:	
ID No:	Group No:	ID No:	Group No:

INJURY INFORMATION

Date of Onset:	Area of Pain:
Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> AUTO <input type="checkbox"/> WORK <input type="checkbox"/> OTHER _____	
How did Injury Occur:	

Race: <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asia <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> other _____ <input type="checkbox"/> Refuse to Report
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asia <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> other _____ <input type="checkbox"/> Refuse to Report
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> other _____

Each Patient (Or Responsible Party) is Financially Responsible for Services rendered. While we are please to assist in the Preparation of Insurance Forms, the obligation for payment of our fees remains that of the patient. I hereby authorize payment to Ventura Orthopedics for Medical Services rendered. I authorize the release of any information required in the course of my examination or treatment.

Responsible Party Name (Please Print)

Date _____

Signature of Responsible Party
