

# Ventura Orthopedics Current Problem Questionnaire

**Instructions:** This is a scanned document, Please fill in the circle  Do not use an X, check mark, or line

<b>Patient Name:</b>		<b>Date:</b>	
<b>DOB:</b>	<b>Height:</b>	<b>Weight</b>	
<b>Referring Physician:</b>		<b>Primary Care Physician:</b>	

- I. Which side is affected?  Right  Left  Bilateral  
 Problem involves the:  Shoulder  Elbow  Forearm  Wrist  Hand  
 Finger  Neck  Hip  Thigh  Knee  
 Leg  Ankle  Foot  Toe  Back
- II. Was there an injury which you believe directly resulted in your symptoms?  Yes  No (If no, skip to IV.)  
 If so, what is the date of injury: \_\_\_\_\_  
 Is the injury work related?  Yes  No  
 Is this the result of a motor vehicle accident?  Yes  No
- III. Please give an approximate time (date, month, or year) when the symptoms began: \_\_\_\_\_
- IV. Describe the injury and/or development of your problem: \_\_\_\_\_  
 \_\_\_\_\_
- V. Have you sought medical treatment for this problem prior to this visit?  Yes  No  
 If so, where:  Emergency Room  Urgent Care  Physician's Office  Other  
 Name of care provider and/or facility who treated you: \_\_\_\_\_  
 What kind of treatment was given?  Brace/Splint  Crutches  Cast  Therapy  Chiropractic  
 What medication was given?  Narcotic (Vicodin, Codeine, etc)  Anti-inflammatory (Advil, Motrin, etc)  
 Muscle Relaxer (Flexeril, Soma, etc)  Corticosteroid (Medrol Dosepak)  Injection  
 Other: \_\_\_\_\_
- VI. Have you had any studies of the **involved area** within the **past year**?  X-Rays  MRI  
 CT/CAT Scan  Nerve Test  Arthrogram  Myelogram  Discogram  
 Have you had surgery on this body part?  Yes  No  
 Have you had symptoms or an injury to this area before?  Yes  No  
 If so, please describe: \_\_\_\_\_
- VII. Are you getting:  Better  Worse  No Change  
 Quality of your pain:  None  Mild  Moderate  Severe  
 Type of pain:  Sharp  Dull  Burning  Aching  Other: \_\_\_\_\_  
 Constant  Present only at times or with certain activities  
 Does the pain radiate:  Yes  No If yes, where on your body: \_\_\_\_\_  
 Is there:  Swelling  Numbness/Tingling  Weakness  A Mass  Deformity

What makes your problem worse? \_\_\_\_\_

What makes your problem better? \_\_\_\_\_

**Pain Diagram**

Using the figures to the right, mark the areas where you feel the described sensation on your body. Use the appropriate symbols (indicated below) and include all affected areas.

**Ache**           +++++

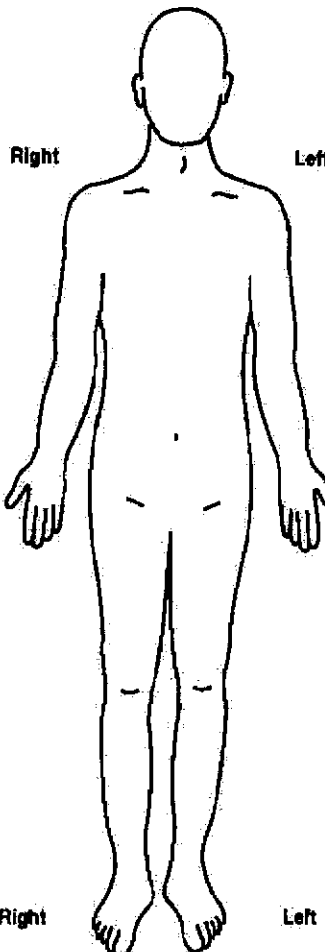
**Numbness**     =====

**Pins & Needles**   o-o-o-o-o-o-o-o

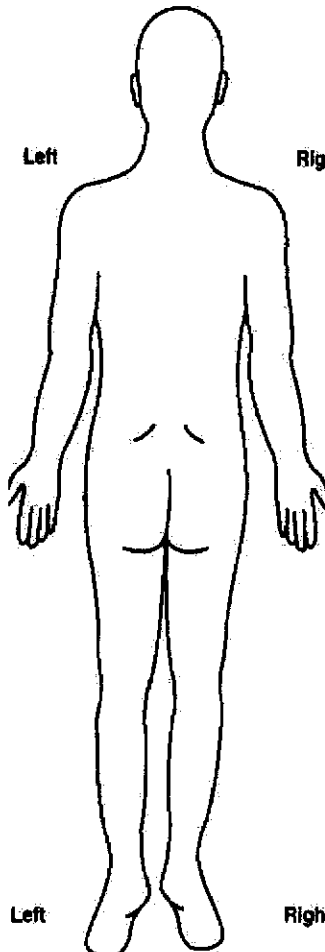
**Burning**         ^ ^ ^ ^ ^ ^ ^ ^

**Stabbing**       // // // // // // // //

**FRONT**



**BACK**



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



# 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

\_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE:** \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_

SUBSCRIBER BIRTHDATE: \_\_\_\_\_

SUBSCRIBER SSN#: \_\_\_\_\_

SUBSCRIBER RELATIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER EMPLOYER: \_\_\_\_\_

ADDRESS/CITY/STATE/ZIP: \_\_\_\_\_

EMPLOYER PHONE: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_

SUBSCRIBER BIRTHDATE: \_\_\_\_\_

SUBSCRIBER SSN#: \_\_\_\_\_

SUBSCRIBER RELATIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER EMPLOYER: \_\_\_\_\_

ADDRESS/CITY/STATE/ZIP: \_\_\_\_\_

EMPLOYER PHONE: \_\_\_\_\_

EACH PATIENT (OR RESPONSIBLE PARTY) IS FINANCIALLY RESPONSIBLE FOR THE SERVICES RENDERED. WHILE WE ARE PLEASED 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.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

# Ventura Orthopedics

**Instructions: This is a scanned document, Please fill in the circle  Do not use an X, check mark, or line**

## PATIENT INFORMATION

<b>Patient Name:</b>		<b>Date:</b>
<b>DOB:</b>	<b>Height:</b>	<b>Weight</b>

- I. Did another doctor send you to this office for evaluation?       Yes       No  
 If yes, who referred you \_\_\_\_\_
- II. Problem involves the:       Right       Left       Bilateral       Shoulder       Elbow  
 Forearm       Wrist       Hand       Finger       Neck       Hip       Thigh  
 Knee       Leg       Ankle       Foot       Toe       Back
- III. Was there an injury which you believe directly resulted in your symptoms?       Yes       No      *(If no, skip to IV.)*  
 Date of Injury: \_\_\_\_\_  
 Is the injury work related?       Yes      Is this the result of a motor vehicle accident?       Yes
- IV: Please give an approximate time (date, month, or year) when the symptoms began: \_\_\_\_\_
- V. Describe the injury and/or development of your problem: \_\_\_\_\_
- VI. Have you sought medical treatment for this problem prior to this visit?       Yes       No  
*If so, where:*       Emergency Room       Urgent Care       Physician's Office       Other  
 Name of care provider and/or facility who treated you: \_\_\_\_\_  
 What kind of treatment was given?       Brace/Splint       Crutches       Cast       Therapy       Chiropractic  
 What medication was given?       Narcotic (Vicodin, Codeine, etc)       Anti-inflammatory (Advil, Motrin, etc)  
 Muscle Relaxer (Flexeril, Soma, etc)       Corticosteroid (Medrol Dosepak)       Injection
- VII. **For the problem you are being seen for today**, have you had any of the following:  
 X-rays       CT scan       MRI       Nerve test  
 Arthrogram       Myelogram       Discogram  
 Have you had surgery on this body part?       Yes       No  
 Have you had symptoms or an injury to this area before?       Yes       No  
 If so, please describe: \_\_\_\_\_
- VIII. Are you experiencing pain at the present time?       Yes       No  
 Pain is described as:       Improved       Worse       The same  
 Mild       Moderate       Severe       Sharp       Dull  
 Burning       Aching       Constant       Present only at times or with certain activities  
 Does the pain radiate:       Yes       No      If yes, where on your body: \_\_\_\_\_  
 Is there:       Swelling       Numbness       Tingling       Weakness  
 A Mass       Deformity
- What makes your problem worse? \_\_\_\_\_
- What makes your problem better? \_\_\_\_\_

## Medical History

- Osteoporosis       Cancer       High Blood Pressure       Heart Disease  
 Diabetes       Paralysis       Arthritis       Ulcers  
 Poor Circulation       Asthma       Other: \_\_\_\_\_

## Social History

- Do you smoke cigarettes?       Yes     No  
How long have you smoked?       <1 year     1-10 years       10+ years  
How many packs per day?       <1     1-2 packs     3+ packs  
Have you smoked cigarettes in the past?       Yes       No  
Do you drink alcohol regularly?       Yes       No  
Drinks per week:       < 4 drinks     5-9 drinks     10 +  
Have you used or do you use other drugs?       None       Street Drugs     Steroids       Other: \_\_\_\_\_  
Level of education completed:       Elementary     High School     College       Graduate  
Marital Status:       Single       Married       Divorced       Widowed

## Family History

- |                     |                                 |                                 |   |                                   |
|---------------------|---------------------------------|---------------------------------|---|-----------------------------------|
| Cancer              | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Heart Failure       | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Heart Attacks       | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Emphysema           | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Diabetes            | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Epilepsy            | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| High Blood Pressure | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Arthritis           | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Alcoholism          | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Stroke              | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Mental Illness      | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Alive               | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |
| Deceased            | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Siblings |

## Review of Systems: Are you experiencing any of these issues now?

Are you pregnant?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A						
<b>General</b>	Fever	<input type="radio"/> Yes	<input type="radio"/> No		Night Sweats/Chills	<input type="radio"/> Yes	<input type="radio"/> No		
	Night Pain	<input type="radio"/> Yes	<input type="radio"/> No		Weight Loss	<input type="radio"/> Yes	<input type="radio"/> No		
<b>Eyes</b>	Cataracts	<input type="radio"/> Yes	<input type="radio"/> No		Blindness	<input type="radio"/> Yes	<input type="radio"/> No		
	Double Vision	<input type="radio"/> Yes	<input type="radio"/> No						
<b>HEENT</b>	Cough	<input type="radio"/> Yes	<input type="radio"/> No		Sinus Problems	<input type="radio"/> Yes	<input type="radio"/> No		
	Sore Throat	<input type="radio"/> Yes	<input type="radio"/> No		Hearing Loss	<input type="radio"/> Yes	<input type="radio"/> No		
	Dentures	<input type="radio"/> Yes	<input type="radio"/> No		Loose Tooth	<input type="radio"/> Yes	<input type="radio"/> No		
<b>Heart</b>	Chest Pain	<input type="radio"/> Yes	<input type="radio"/> No		Irregular Heart Beats	<input type="radio"/> Yes	<input type="radio"/> No		
	High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No						
<b>Lungs</b>	Wheezing	<input type="radio"/> Yes	<input type="radio"/> No		Shortness of Breath	<input type="radio"/> Yes	<input type="radio"/> No		
	Pain with Breathing	<input type="radio"/> Yes	<input type="radio"/> No		Sputum Production	<input type="radio"/> Yes	<input type="radio"/> No		
<b>Abdominal</b>	Heartburn	<input type="radio"/> Yes	<input type="radio"/> No		Difficult Swallowing	<input type="radio"/> Yes	<input type="radio"/> No		
	Nausea & Vomiting	<input type="radio"/> Yes	<input type="radio"/> No						
<b>Urinary</b>	Blood in Urine	<input type="radio"/> Yes	<input type="radio"/> No		Pain with Urination	<input type="radio"/> Yes	<input type="radio"/> No		
	Incontinence	<input type="radio"/> Yes	<input type="radio"/> No		Kidney Stones	<input type="radio"/> Yes	<input type="radio"/> No		
<b>Musculoskeletal</b>									
	Joint Swelling	<input type="radio"/> Yes	<input type="radio"/> No		Joint Redness	<input type="radio"/> Yes	<input type="radio"/> No		
	Muscle Cramps	<input type="radio"/> Yes	<input type="radio"/> No		Stiffness	<input type="radio"/> Yes	<input type="radio"/> No		
<b>Skin &amp; Breast</b>	Rash	<input type="radio"/> Yes	<input type="radio"/> No		Changes in Moles	<input type="radio"/> Yes	<input type="radio"/> No		
	Lumps	<input type="radio"/> Yes	<input type="radio"/> No		Discharge	<input type="radio"/> Yes	<input type="radio"/> No		
<b>Neurologic</b>	Seizures	<input type="radio"/> Yes	<input type="radio"/> No		Loss of Consciousness	<input type="radio"/> Yes	<input type="radio"/> No		
	Tremor	<input type="radio"/> Yes	<input type="radio"/> No		Paralysis	<input type="radio"/> Yes	<input type="radio"/> No		
	Balance Problems	<input type="radio"/> Yes	<input type="radio"/> No		Headaches	<input type="radio"/> Yes	<input type="radio"/> No		
<b>Psychiatric</b>	Depression	<input type="radio"/> Yes	<input type="radio"/> No		Hyperactivity	<input type="radio"/> Yes	<input type="radio"/> No		
	Difficulty Sleeping	<input type="radio"/> Yes	<input type="radio"/> No		Loss of Appetite	<input type="radio"/> Yes	<input type="radio"/> No		
	Social Withdrawal	<input type="radio"/> Yes	<input type="radio"/> No						
<b>Metabolism</b>	Weight Gain	<input type="radio"/> Yes	<input type="radio"/> No		High Blood Sugar	<input type="radio"/> Yes	<input type="radio"/> No		
	Clammy	<input type="radio"/> Yes	<input type="radio"/> No		Tired	<input type="radio"/> Yes	<input type="radio"/> No		
<b>Blood</b>	Anemia	<input type="radio"/> Yes	<input type="radio"/> No		Prolonged Bleeding	<input type="radio"/> Yes	<input type="radio"/> No		

## Allergies

Are you allergic to any medications?

Yes  No

Please list:

**Pain Diagram**

Using the figures to the right, mark the areas where you feel the described sensation on your body. Use the appropriate symbols (*indicated below*) and include all affected areas.

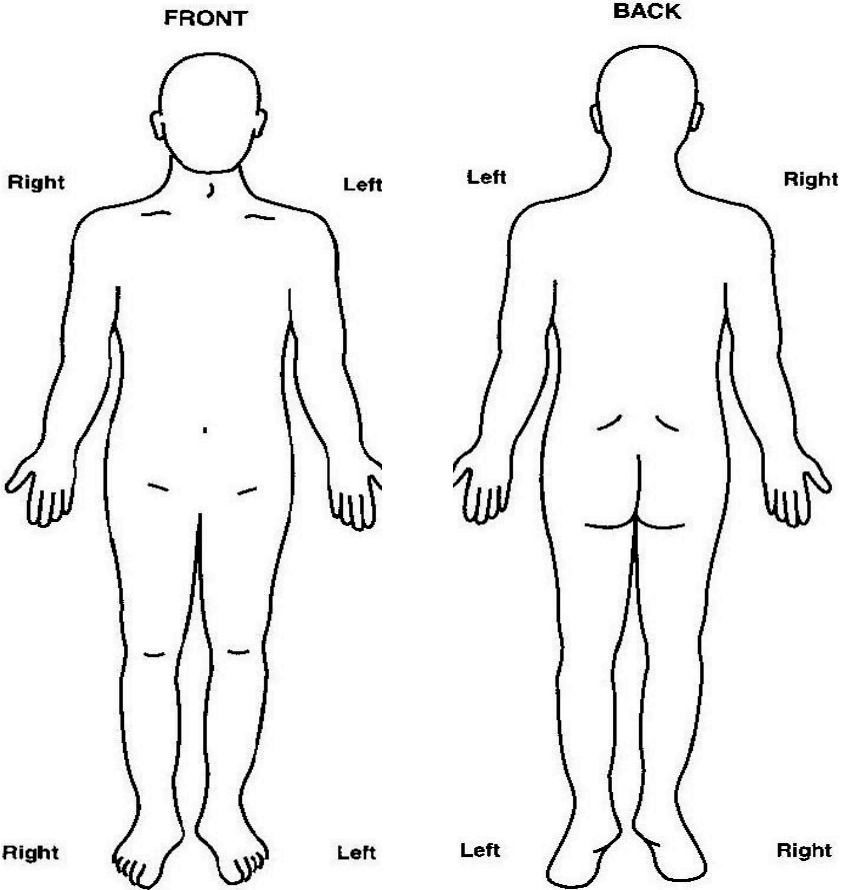
**Ache**            ++++++++  
                     ++++++++

**Numbness**     =====  
                     =====

**Pins & Needles** 0000000  
                     0000000

**Burning**        ^^^^^^^  
                     ^^^^^^^

**Stabbing**       ///////////////  
                     ///////////////



Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



## Acknowledgement of Receipt of Notice of Privacy Practices

3525 loma vista road  
ventura, ca 93003

2100 solar drive, suite 102  
oxnard, ca 93036

117 pirie road, suite e  
ojai, ca 93023

3695 alamo street, suite 100  
simi valley, ca 93063

2230 lynn road, suite 220  
thousand oaks, ca 91360

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices.

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Signature

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Date

---

Print Name

---

Telephone Number

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_