

Date: \_\_\_\_\_

### AOA Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ AKA: \_\_\_\_\_

Date of Birth: \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex: ☐ Male ☐ Female Marital Status : \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred language: \_\_\_\_\_

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ E-mail Address: \_\_\_\_\_

Preferred contact number \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Preferred Confirmation Method (Choose One): ☐ CALL ☐ TEXT ☐ EMAIL ☐ OPT OUT

Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address if different \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Pharmacy for eRX: \_\_\_\_\_ Responsible Party Name: \_\_\_\_\_

### Emergency Contact

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Does the emergency contact have permission to make Medical Decisions? ☐ YES ☐ NO

### PRIMARY INSURANCE

Please Fill out ALL Your Insurance Information

Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Policy Holder: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ D.O.B \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance ID Number \_\_\_\_\_ Group ID Number \_\_\_\_\_ SSN \_\_\_\_\_

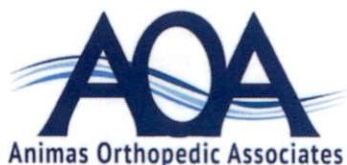
### SECONDARY INSURANCE

Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Policy Holder: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ D.O.B \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance ID Number \_\_\_\_\_ Group ID Number \_\_\_\_\_ SSN \_\_\_\_\_

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



## New Problem Questionnaire

*Please Check a box as appropriate*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

1) Sex: ☐ Male or ☐ Female Height \_\_\_\_\_ Weight \_\_\_\_\_

2) Are you ☐ Right or ☐ Left Handed?

3) What brings you in today? ☐ Right ☐ Left Body Part: \_\_\_\_\_

(other important details) \_\_\_\_\_

4) What is your main problem?

☐ Pain

☐ Unstable or Dislocating Joint

☐ Numbness

☐ Swelling

☐ Weakness

☐ Stiffness

☐ Other (explain): \_\_\_\_\_

5) How did your problem start? (give details as needed)

☐ Job Injury

☐ Sports Injury

☐ Motor Vehicle Accident

☐ Gradual or Slow Onset

☐ Other (explain): \_\_\_\_\_

6) How long have you had this problem, approximately? \_\_\_\_\_

7) Is your pain: ☐ Aching ☐ Burning ☐ Dull ☐ Piercing ☐ Sharp ☐ Throbbing

8) Is your problem:

☐ Improving

☐ Worsening

☐ Staying the Same

9) Does your pain or problem awaken you from sleep? ☐ Yes ☐ No

10) Is your pain or problem intermittent? ☐ Yes ☐ No or Constant? ☐ Yes ☐ No

11) What worsens your problem? (give details as needed)

☐ Exercise

☐ Repetitive Motions

☐ Nothing

☐ Sitting

☐ Overhead Activities

☐ Rest

☐ Standing

☐ Going up and down stairs

☐ Walking

☐ Other (explain): \_\_\_\_\_

12) What helps your problem? ☐ Brace ☐ Elevation ☐ Heat ☐ Ice ☐ Injection

☐ Massage ☐ Pain meds ☐ NSAIDs ☐ Physical therapy ☐ Rest ☐ Stretching ☐ Nothing

Other (explain): \_\_\_\_\_

13) Are routine activities or walking limited because of your problem? ☐ Yes ☐ No

14) Do you use any assistive devices? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: \_\_\_\_\_

15) What tests have you had?

☐ X-rays

☐ Nerve Test (EMG or NCV)

☐ CT Scan or MRI

☐ Ultrasound

☐ Other: \_\_\_\_\_

17) What medicines are you taking for this problem? \_\_\_\_\_

18) Are you on or applying to any of the following programs because of your problem?

☐ Disability

☐ Worker's Compensation

19) What is your occupation?

\_\_\_\_\_

20) What is your present work status?

☐ Not Working

Date last worked: \_\_\_\_\_

☐ Light Duty

For how long? \_\_\_\_\_

☐ Regular Duty, no restrictions

21) If you are working, does your job require the following?

☐ Lifting How Many Pounds: \_\_\_\_\_

☐ Extended Walking

☐ Frequent Bending & Lifting

☐ Continuous Standing

☐ Frequent Squatting or Kneeling

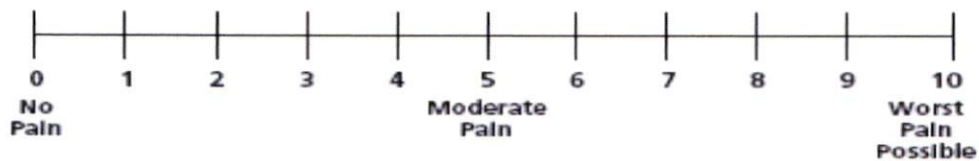
☐ Sitting

☐ Climbing

☐ Repetitive Motions

22) Any other acute problems in your life right now or anything else regarding your problem that you wish us to know? \_\_\_\_\_

23) Please make a mark on the scale regarding the severity of your problem.

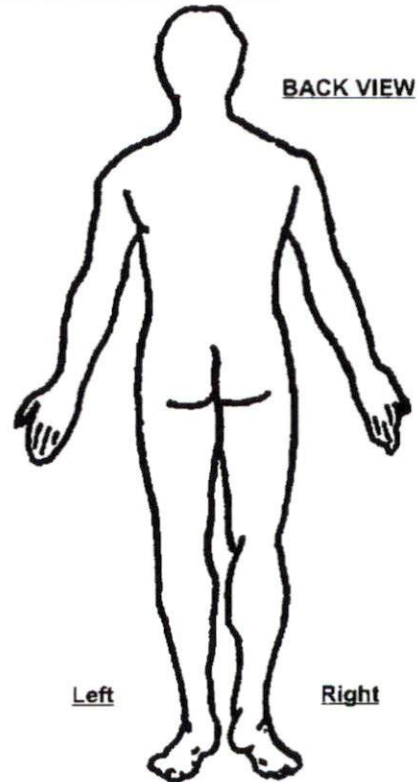
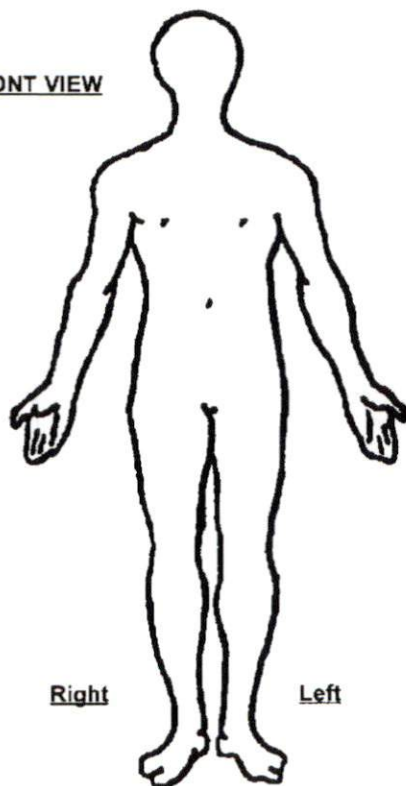


24) Mark the area(s) on your body where you feel the sensations described below, using the appropriate symbol. Include all pertinent areas and radiating pain.

○ Ache / Sharp Pain    Δ Burning or Tingling    # Numbness

FRONT VIEW

BACK VIEW



To complete the picture, draw in your face and place an "X" where the pain is worst now

X \_\_\_\_\_  
Signature of Patient, Parent, or Guardian

\_\_\_\_\_ Date

X \_\_\_\_\_  
Reviewed by MD

# General Medical History Worksheet

*Check boxes and fill in information as appropriate*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Who are your primary doctor(s) to whom reports should be sent? \_\_\_\_\_

## Past Medical History

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Diabetes/High Blood Sugar | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack/Heart Disease           | <input type="checkbox"/> Lung Disease/Emphysema (explain): _____               |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Sleep Apnea         | <input type="checkbox"/> Gout                                 | <input type="checkbox"/> Prior Fractures/Broken Bones (explain): _____         |
| <input type="checkbox"/> Varicose Veins            | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Psychiatric Problems                 | <input type="checkbox"/> Inflammatory Arthritis (Rheumatoid, Lupus, Psoriatic) |
| <input type="checkbox"/> Fibromyalgia              | <input type="checkbox"/> Stroke/T.I.A.       | <input type="checkbox"/> High Cholesterol                     | <input type="checkbox"/> Bowel and GI Problems: (explain): _____               |
| <input type="checkbox"/> Urinary Tract Infections  | <input type="checkbox"/> Anemia/Hemophilia   | <input type="checkbox"/> Blood Clot/Deep Vein Thrombosis      | <input type="checkbox"/> Serious Infections (explain): _____                   |
| <input type="checkbox"/> HIV/AIDS                  | <input type="checkbox"/> Breast Disease      | <input type="checkbox"/> Poor Circulation or Vascular Disease | <input type="checkbox"/> Sexually Transmitted Disease (explain): _____         |
| <input type="checkbox"/> Prostate Disease          | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Eating Disorder/Poor Nutrition       | <input type="checkbox"/> Skin Disease (explain): _____                         |
| <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Gastric Ulcers                       | <input type="checkbox"/> Hepatitis ("Jaundice")/Liver Disease                  |

Cancer History (type and current status): \_\_\_\_\_

Other Medical Problems: \_\_\_\_\_

## Prior Hospitalizations and Surgical History

☐ No Past Medical History

Type of Surgery/Reason for Hospitalization	Date	Surgeon/Physician
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

## Current Medications (include herbal supplements and attach sheet if necessary) ☐ Taking No Medication

Name of Medication	Dose/Strength	Schedule Taken
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

## Allergies to Medication or Materials

☐ No Known

Allergen	Reaction
1. _____	_____
2. _____	_____
3. _____	_____

## Social Background

Marital Status: ☐ Married ☐ Domestic Partnership ☐ Single ☐ Divorced ☐ Widowed

Age(s) of children: \_\_\_\_\_ Can someone care for you at home? ☐ No ☐ Yes, who? \_\_\_\_\_

Do you drink caffeinated beverages? ☐ No ☐ Yes If so, how much per day? \_\_\_\_\_

Do you have a history of illicit drug use? ☐ No ☐ Yes If so, explain: \_\_\_\_\_

Do you use tobacco? ☐ No ☐ Yes If so, how much/packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Previously used tobacco? ☐ No ☐ Yes If so, did you quit ☐ 1 year ago ☐ >5 years ago ☐ >10 years ago

Do you drink alcohol? ☐ No ☐ Occasionally ☐ Daily How much? \_\_\_\_\_

## Family Medical History

Relation	Age	State of Health	Age of Death	Medical Problems/Cause of Death
Mother				
Father				
Siblings <input type="checkbox"/> Bro <input type="checkbox"/> Sis				
Siblings <input type="checkbox"/> Bro <input type="checkbox"/> Sis				
Siblings <input type="checkbox"/> Bro <input type="checkbox"/> Sis				
Grandfather (maternal)				
Grandmother (maternal)				
Grandfather (paternal)				
Grandmother (paternal)				

## Review of Systems: Are you currently having or have you had a problem with:

Condition	Check a Box	Please Describe all "Yes" Responses
Fever or Shaking Chills	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Weight Loss (not diet related)	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Chest Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Lung or Breathing Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Irregular Heart Beat	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Problems Urinating	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Loss of Strength or Numb/Tingling	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Bowel or Stool Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Vision Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Skin Issues	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Pregnancy or Menstrual Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Lumps or Masses (incl. breast)	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Fainting/Seizures/Blackout	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Bleeding or Blood Clots	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Psychiatric Issues	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Problems with Anesthesia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Ears, Nose or Throat	<input type="checkbox"/> No <input type="checkbox"/> Yes	

X \_\_\_\_\_  
Signature of Patient, Parent, of Guardian

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Reviewed by MD