



Patient Name:  
D.O.B:        Age:  
Date:



**HIPAA Authorization to Release Medical Information**

Due to HIPAA Regulations and our promise to provide you with the utmost privacy, this HIPAA Authorization to Release Medical Information Form is designed to allow only certain people whom you select to have access to your medical information. (For example: your spouse, children, or family friend (this form only pertains to family and friends)). **I hereby authorize the following people to have access to my medical information:**

(This includes but is not limited to sitting in during my consultations with the physician and calling the office to check my medical status. This authorization will hold in effect until I submit a written notice of any changes.)

<b>Name</b>	<b>Relationship</b>	<b>Phone Number</b>	<b>Authorization Date</b>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**Patient Signature:** \_\_\_\_\_

**Our office utilizes an automated appointment system and we would like to include you if interested in receiving appointment reminders.**

**Yes, I am interested** \_\_\_\_\_ **(Please check)**

I would prefer    TEXT (SMS) \_\_\_\_\_    VOICE CALLS \_\_\_\_\_

Please update your contact information:

Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

**No, I am not interested in receiving automated appointment reminders. I would prefer the office staff to call me.**

\_\_\_\_\_ **(Please check)**

Thank you for taking time to complete this form.



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### Medical History

Sex/Gender:  M  F  Other Primary Care Physician: \_\_\_\_\_ Who referred you to our clinic? \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Is this work related?  Yes  No If work related, was it reported?  Yes  No  
 Case manager or adjuster: \_\_\_\_\_

**Current Medications:** Include prescription, non-prescription medications & herbal supplements . **If you have a list, please provide.**

I give Tru Ortho permission to obtain my medication history from External Prescription history if needed.

Name of Medication or supplement	Dosage (ie. Milligrams)	How often do you take it? (ie 1 tablet daily)

<b>Allergies to Medications:</b> _____	_____
Drug Name: _____	Drug Name: _____
Type of Reaction _____	Type of Reaction _____

**Do you have any allergy or sensitivity to metal?**  Yes  No      **Have you ever had an adverse reaction to anesthesia?**  yes  No

**Past Medical History: Have you ever had any of the following? If yes, please check boxes:**

<p><b><u>BLOOD</u></b>  <input type="checkbox"/> Anemia    <input type="checkbox"/> Hemophilia    <input type="checkbox"/> Sickle Cell    <input type="checkbox"/> DVT  <input type="checkbox"/> Clotting problems    <input type="checkbox"/> Other: _____</p>	<p><b><u>INTEGUMENTARY (Skin/Nails)</u></b>  <input type="checkbox"/> Cellulitis    <input type="checkbox"/> Eczema    <input type="checkbox"/> Shingles    <input type="checkbox"/> Rosacea  <input type="checkbox"/> Contact Dermatitis    <input type="checkbox"/> Psoriasis    <input type="checkbox"/> Other: _____</p>
<p><b><u>CANCER</u></b>  <input type="checkbox"/> Breast    <input type="checkbox"/> Liver    <input type="checkbox"/> Prostate    <input type="checkbox"/> Skin    <input type="checkbox"/> Lung  <input type="checkbox"/> Leukemia    <input type="checkbox"/> Kidney    <input type="checkbox"/> Ovarian    <input type="checkbox"/> Colon    <input type="checkbox"/> Cervical  <input type="checkbox"/> Uterine                    <input type="checkbox"/> Other: _____</p>	<p><b><u>REPRODUCTIVE</u></b>          Currently Pregnant? <input type="checkbox"/> Yes    <input type="checkbox"/> No    LMP: _____          Currently Breastfeeding? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p><b><u>RESPIRATORY</u></b>  <input type="checkbox"/> Asthma    <input type="checkbox"/> Bronchitis    <input type="checkbox"/> Emphysema    <input type="checkbox"/> COPD  <input type="checkbox"/> Pneumonia    <input type="checkbox"/> Clot in lungs (pulmonary embolus)  <input type="checkbox"/> Other: _____</p>	<p><b><u>PSYCHOLOGICAL</u></b>  <input type="checkbox"/> ADD    <input type="checkbox"/> ADHD    <input type="checkbox"/> Depression    <input type="checkbox"/> Panic Disorder  <input type="checkbox"/> Bipolar Disorder    <input type="checkbox"/> PTSD    <input type="checkbox"/> Anxiety    <input type="checkbox"/> Schizophrenia  <input type="checkbox"/> Autism    <input type="checkbox"/> Other: _____</p>
<p><b><u>INFECTIOUS DISEASE</u></b>  <input type="checkbox"/> AIDS    <input type="checkbox"/> HIV    <input type="checkbox"/> Hepatitis A/B/C    <input type="checkbox"/> Tuberculosis  <input type="checkbox"/> MRSA/VRE (resistant org)    <input type="checkbox"/> Covid 19  <input type="checkbox"/> Covid Vaccine completed    <input type="checkbox"/> Other: _____</p>	<p><b><u>CARDIAC</u></b>  <input type="checkbox"/> Aneurysm    <input type="checkbox"/> Chest pain/angina    <input type="checkbox"/> Cardiac bypass surgery  <input type="checkbox"/> Pacemaker    <input type="checkbox"/> Heart Murmur    <input type="checkbox"/> Congestive heart failure  <input type="checkbox"/> Heart attack    <input type="checkbox"/> High blood pressure    <input type="checkbox"/> Irregular Heartbeat  <input type="checkbox"/> High Cholesterol    <input type="checkbox"/> Other: _____</p>
<p><b><u>EENT (Eyes/Ears/Nose/Throat)</u></b>  <input type="checkbox"/> Seasonal Allergies    <input type="checkbox"/> Hearing loss    <input type="checkbox"/> Glaucoma  <input type="checkbox"/> Cataract- Left    <input type="checkbox"/> Cataract- Right  <input type="checkbox"/> Hearing device- Left    <input type="checkbox"/> Hearing device- Right  <input type="checkbox"/> Chronic Sinusitis    <input type="checkbox"/> Corrective Lenses  <input type="checkbox"/> Other: _____</p>	<p><b><u>ENDOCRINE (Diabetes/Thyroid/Pancreas)</u></b>  <input type="checkbox"/> DM Type I    <input type="checkbox"/> DM Type II    <input type="checkbox"/> Hashimoto's  <input type="checkbox"/> Hyperthyroidism    <input type="checkbox"/> Hypothyroidism    <input type="checkbox"/> Addison's  <input type="checkbox"/> Cushing    <input type="checkbox"/> Graves'  <input type="checkbox"/> Other: _____</p>

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<b>MUSCULOSKELETAL</b> <b>(Bones/Muscles/Ligament/Tendons/Joints)</b> <input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Chronic <b>back</b> pain <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Chronic <b>neck</b> pain <input type="checkbox"/> Gout <input type="checkbox"/> Lupus or Scleroderma <input type="checkbox"/> Other: _____	<b>URINARY (Kidney/Bladder)</b> <input type="checkbox"/> Prostate disease (BPH/Enlarged prostate) <input type="checkbox"/> Cystitis <input type="checkbox"/> Dialysis <input type="checkbox"/> Urinary retention <input type="checkbox"/> Kidney stones <input type="checkbox"/> Chronic renal disease <input type="checkbox"/> Incontinence <input type="checkbox"/> UTI chronic <input type="checkbox"/> Self Catherization <input type="checkbox"/> Other: _____
<b>NEUROLOGICAL (Brain/Spinal cord)</b> <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia <input type="checkbox"/> Parkinson's <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Stroke <input type="checkbox"/> TIA (Any residual deficits?) _____ <input type="checkbox"/> Paralysis (Quadra or Paraplegia) <input type="checkbox"/> Other: _____	<b>GASTROINTESTINAL (Digestive/Esophagus/Stomach/Colon/Rectum)</b> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> GERD <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Gastrointestinal bleeding <input type="checkbox"/> Other: _____

**Past Surgical History: Please list ANY past surgeries.**

Date	Surgery	Surgeon	Date	Surgery	Surgeon

**Hospitalizations:**    For surgeries    Others: \_\_\_\_\_    None

**Family History:**    Adopted    None

**Social History:**

	Mother	Father	Sibling	Other	Unknown					
<b>Heart/Cardiac Disease</b>	<input type="checkbox"/>	<b>Alcohol use</b>	<input type="checkbox"/> No	<input type="checkbox"/> Rare	<input type="checkbox"/> Moderate	<input type="checkbox"/> Daily				
<b>Cancer</b>	<input type="checkbox"/>	<b>Do you exercise regularly?</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes						
<b>Diabetes</b>	<input type="checkbox"/>	<b>Drug use</b>	<input type="checkbox"/> None	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Other					
<b>High Blood Pressure</b>	<input type="checkbox"/>	<b>Marital Status</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced				
<b>Malignant Hyperthermia</b>	<input type="checkbox"/>	<b>Living status</b>	<input type="checkbox"/> With Family	<input type="checkbox"/> With Friends	<input type="checkbox"/> Alone	<input type="checkbox"/> Other				
<b>Stroke (CVA/TIA)</b>	<input type="checkbox"/>	<b>Do you follow special diet?</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes If so, What?						
<b>Bleeding Disorders (hemophilia, etc.)</b>	<input type="checkbox"/>	<b>Tobacco use</b>	<input type="checkbox"/> Never	<input type="checkbox"/> Quit	<input type="checkbox"/> Dip /vaping	<input type="checkbox"/> Yes ____packs/day x ____ year(s)				
<b>Adverse reaction to anesthesia</b>	<input type="checkbox"/>	<b>Please list your hobbies:</b>								
<b>If deceased, at what age?</b>						<b>What do you do for work?</b>				

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**Review of Systems: Please check current symptoms that you have:**

General	<input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Exercise intolerance
Allergy/Immunology	<input type="checkbox"/> Itching <input type="checkbox"/> Hives <input type="checkbox"/> Sneezing <input type="checkbox"/> Sinus pressure
Eyes	<input type="checkbox"/> Irritation <input type="checkbox"/> Dryness <input type="checkbox"/> Change in vision <input type="checkbox"/> Corrective Lenses
ENT	<input type="checkbox"/> Hearing loss <input type="checkbox"/> Bleeding gums/nosebleeds <input type="checkbox"/> Sinus problems <input type="checkbox"/> Dry mouth <input type="checkbox"/> Active Dental issues
Endocrine	<input type="checkbox"/> Fatigue <input type="checkbox"/> Excessive Thirst
Respiratory	<input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty breathing
Cardiovascular	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart murmur
Gastrointestinal	<input type="checkbox"/> Vomiting/nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Blood stool
Hematology	<input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendency
Genitourinary	<input type="checkbox"/> Incontinence <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Frequent urination
Musculoskeletal	<input type="checkbox"/> Joint pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Back/neck pain <input type="checkbox"/> Muscle pain/ache/cramps <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Weakness <input type="checkbox"/> Balance problems
Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Open wound or ulcer <input type="checkbox"/> Cellulitis
Neurologic	<input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Weakness <input type="checkbox"/> Light headed/dizzy
Psychiatric	<input type="checkbox"/> Depressed mode <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Anxiety

To the best of my knowledge, the questions on this form have been answered correctly. I understand that it is my responsibility to inform the doctor of any changes in my medical condition.

\_\_\_\_\_  
 Signature of Patient, or Parent Minor

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Physician Initials/Date

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1. Where is the pain located- circle? **Hip:** Left / Right **Knee:** Left / Right **Ankle:** Left / Right **Foot:** Left/Right **Shoulder:** Left/Right

2. Have you EVER worn a Brace or wrap for this joint? Yes No
3. Have you EVER tried ice or heat for this joint? Yes No
4. Have you EVER required assistance to walking (cane, walker, wheelchair)? Yes No
5. Have you EVER had physical therapy or done exercises for this joint? Yes No If so, when? \_\_\_\_\_
6. Have you EVER had surgery for this joint? Yes No
7. Have you EVER taken any medication for this joint? Yes No
- \_\_\_ Motrin/Ibuprofen/Advil/Naproxen/Aleve
  - \_\_\_ Voltaren/Diclofenac
  - \_\_\_ Tylenol
  - \_\_\_ Aspirin
  - \_\_\_ Mobic/Meloxicam
  - \_\_\_ Celebrex
  - \_\_\_ Narcotics
  - \_\_\_ Others: \_\_\_\_\_

8. Have you EVER had an injection in this joint? Yes No
- \_\_\_ Cortisone
  - \_\_\_ Rooster Comb/Cox Comb/Hyaluronic Acid (knee) If so how many? \_\_\_\_\_
  - \_\_\_ Stem Cell/Amnion How long did you have relief for? \_\_\_\_\_

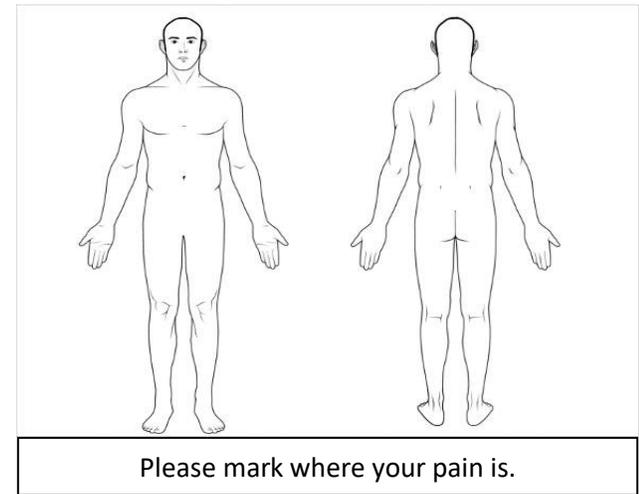
9. Please check ALL activities in which you have EVER noticed pain:
- \_\_\_ Sleeping
  - \_\_\_ Putting on socks or shoes.
  - \_\_\_ Sit and Stand.
  - \_\_\_ Walking
  - \_\_\_ In/Out of Car
  - \_\_\_ Sitting for long periods of time.

10. Does the joint feel unstable? Yes No  
If so, how much (On a scale of 1-10 w/10 being very unstable)? \_\_\_\_\_

11. How long have you had this problem? \_\_\_\_\_

12. Quality of pain:
- \_\_\_ Sharp
  - \_\_\_ Throbbing
  - \_\_\_ Dull
  - \_\_\_ Tight
  - \_\_\_ Tingling
  - \_\_\_ Radiating
  - \_\_\_ Burning
13. Location of pain:
- \_\_\_ Inside (close to center of body)
  - \_\_\_ Outside (away from center of body)
  - \_\_\_ Front
  - \_\_\_ Back
14. Severity of pain: \_\_\_\_\_  
(On a scale of 1-10 w/10 being most severe)

15. Timing of pain:
- \_\_\_ Rare
  - \_\_\_ Intermittent
  - \_\_\_ Constant
16. Associated signs/symptoms:
- \_\_\_ Gridding
  - \_\_\_ Popping
  - \_\_\_ Weakness
  - \_\_\_ Numbness
  - \_\_\_ Swelling
  - \_\_\_ Stiffness
  - \_\_\_ Clicking
  - \_\_\_ Night pain



17. Context (What were you doing at the onset of pain)?  
\_\_\_\_\_

18. Have you seen anyone else for this issue?  
\_\_\_\_\_  
\_\_\_\_\_

**Office Use ONLY:**

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **BMI:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **HR:** \_\_\_\_\_ **Temp:** \_\_\_\_\_