GARDEN STATE ORTHOPAEDICS
Patient Registration Form

Account #: _____ Date:_____Referred by: Dr. _____

Attorney_____

Name: _____ Address: _____

Address:_____ City:_____State:_____Zip:_____

City:_____State:_____Zip:_____ Phone:_____

Home phone#:_____

Other phone#:_____ ☐ cell ☐ work (please specify)

Sex:_____ Date of Birth:_____ Age:_____ SSN:_____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Unemployed

Employer Name: _____ Phone: _____

Address: _____ Occupation: _____

Type of accident

Date of accident:_____

☐ Motor Vehicle Accident

☐ Work related

☐ Other: please specify place of accident:_____

Primary Insurance Carrier:_____ Claim/policy number:_____

Address:_____ Policy Holder:_____

_____

Motor Vehicle: Insurance Co. Name_____Insured's Name:_____

Address:_____Did you file an accident report? ☐ YES ☐ NO

Policy#_____Claim#_____Adjuster:_____Phone#_____

Work Related: Insurance Co. Name_____Insured's Name:_____

Address:_____Did you file an accident report? ☐ YES ☐ NO

Policy#_____Claim#_____Adjuster:_____Phone#_____

Secondary Insurance Carrier:_____Subscriber:_____

Address:_____

ID Number:_____ Group Number:_____Relationship to subscriber:_____

Insured's Name:_____ SS#:_____ DOB:_____

If HMO, Name of Primary Dr._____ Phone#:_____

REASON FOR VISIT: ☐ Medical ☐ Accident related

If accident, state cause: ☐ Auto accident ☐ Auto accident work related ☐ At work ☐ At home

☐ Fall on another's property ☐ At school ☐ Other

Date of accident:_____Did you go to a hospital/ER? ☐ YES ☐ NO

If yes, where?_____Were you taken by ambulance? ☐ YES ☐ NO

Were x-ray-rays taken? ☐ YES ☐ NO If yes, of what body part(s)?_____

Referring Physician:_____ Address:_____ Phone#_____

Family Physician:_____ Address:_____ Phone#_____

ACCIDENT INFORMATION

Height_____Weight_____Age_____ ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Date of accident:_____

Where did this accident/injury take place?_____

How did it happen?_____

What body parts were injured during the accident? _____

What was your position sitting in the vehicle?

☐ Driver ☐ Front passenger ☐ Rear right ☐ Rear left ☐ Other_____

Were you wearing a seat belt? ☐ YES ☐ NO (☐ harness ☐ lap belt ☐ both)

Was your car ☐ Moving or ☐ Stopped in traffic OR ☐ Stopped?

If moving, what was your approximately speed at the time of impact? _____mph

Were you ☐ hit or did you ☐ hit another vehicle?

If you were hit, where?: ☐ rear ended ☐ back driver's side ☐ back passenger's side ☐ head on

☐ front driver's side ☐ front passenger's side ☐ other_____

If you were the driver, did you have both hands on the steering wheel? ☐ YES ☐ NO ☐ Other_____

If you were the passenger, did you brace with your hands on impact? ☐ YES ☐ NO

Did any part of your body come in contact with any part of the vehicle? ☐ YES ☐ NO

If yes, describe:_____

_____

Describe your body movement at the time of impact:_____

_____

How many vehicles were involved in the accident? _____

Did you lose consciousness? ☐ YES ☐ NO If yes, for how long?_____

Did you go to the hospital? ☐ YES ☐ NO If yes, when?_____

Were you taken by ambulance? ☐ YES ☐ NO Name of hospital:_____

Since the accident/injury, do you have trouble with the following? (please check all that are appropriate)

☐ physical exercise ☐ bending ☐ crawling ☐ sitting ☐ stiffness ☐ driving ☐ walking ☐ standing

☐ lifting ☐ kneeling ☐ climbing stairs ☐ sleeping ☐ overhead work ☐ getting up in the morning

Since the accident/injury, what are you having trouble doing (include sports, problems at work, household chores, etc.)?

_____

_____

Due to your injuries, what are your current symptoms?

☐ Nausea ☐ Vomiting ☐ Dizziness ☐ Fainting ☐ Nervousness

Do you have pain in your: ☐ Head ☐ Neck ☐ Chest ☐ Abdomen ☐ Mid back ☐ Low back

☐ R shoulder ☐ L shoulder ☐ R arm ☐ L arm ☐ R hand ☐ L hand ☐ R wrist ☐ L wrist

☐ R leg ☐ L leg ☐ R knee ☐ L knee ☐ R foot ☐ L foot ☐ R ankle ☐ L ankle

Are there any complaints of numbness or tingling?_____

How frequent is your pain? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

What makes the pain worse? _____

What makes the pain better? _____

Did you seek treatment with a doctor after the hospital? ☐ YES ☐ NO

Name of Doctor	Specialty	Date of 1st Visit	Still treating with doctor?

What tests did you have done?	Where were they done?	On what body part(s)?
X-rays		
MRI___		
CT scan		
EMG		

Did you have any physical therapy treatment? ☐ YES ☐ NO If yes, where?_____

Did you have any chiropractic treatment? ☐ YES ☐ NO If yes, where?_____

When did you start treatment?_____ Are you currently going? ☐ YES ☐ NO

What type(s) of treatment have you received? ☐ Hot packs ☐ Electric stimulation ☐ Exercise

☐ Ultrasound ☐ Traction ☐ Ice ☐ Manipulation

☐ Other_____

How often do you or did you go?_____How long did you go?_____

Has it been helpful? ☐ YES ☐ NO

Have you missed any work due to the accident? ☐ YES ☐ NO If yes, how long?_____

MEDICAL HISTORY

Have you had any prior motor vehicle accidents or significant injuries? ☐ YES ☐ NO If yes, when?_____

What areas of the body were involved in any PRIOR accident?_____

Were these injuries resolved prior to your current injuries? ☐ YES ☐ NO

If no, what complaints remained?_____

Are you still treating for these injuries? ☐ YES ☐ NO

List any fractures/sprains:_____

List any surgeries:_____

Current medical problems: ☐ Hypertension ☐ Diabetes ☐ Asthma ☐ Epilepsy/seizure disorder

☐ Heart attack ☐ Migraines ☐ Stroke ☐ Cardiac disease ☐ Ulcers ☐ Cancer

☐ Anemia ☐ Thyroid disease ☐ Other_____

List current medications:_____

Are you allergic to any medications? ☐ YES ☐ NO

If yes, please list medications:_____

EMPLOYMENT HISTORY (if work-related)

When the accident/injury occurred, did you have a job? ☐ YES ☐ NO

Job title:_____

Job description:_____☐ Full time ☐ Part time_____hrs/wk

Job duties: Lifting/carrying_____lbs. Sitting_____hrs/wk

Standing_____hrs/wk Walking_____ hrs/wk

Did you miss time from work due to accident/injury? ☐ YES ☐ NO Date first missed work:_____

If yes, how much time?_____days/months Date returned to work:_____

Current employer:_____

Employer for work comp claim at time of injury:_____

Hours worked weekly:_____ Years at job:_____

Are you actively working now? ☐ YES ☐ NO

If yes: ☐ same job (same duties) ☐ same job (different duties) ☐ new job ☐ side jobs

☐ Any work restrictions?_____

☐ List duties_____

Employment history (last five years):

Employer's Name	Job Description	Years Worked

SOCIAL HISTORY:

Do you use tobacco? ☐ YES ☐ NO Do you drink alcohol? ☐ YES ☐ NO

How many packs of cigarettes per day?_____ How many drinks per day?_____

How many years have you smoked?_____ If you quit, when?_____

FAMILY HISTORY:

Have any family members had the following:

☐ diabetes, who?_____ ☐ cancer, who?_____

☐ heart disease, who?_____ ☐ arthritis, who?_____

☐ other disease(s), who?_____

FAMILY PHYSICIAN: Name:_____

Address:_____

_____

Phone #:_____

PATIENT'S SIGNATURE: _____

TODAY'S DATE:_____

PATIENT NAME: _____DATE:_____

SYSTEM REVIEW

CONSTITUTIONAL SYMPTOMS

Good general health lately	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Headaches	YES	NO

EYES

Eye disease or injury	YES	NO
Wear glasses or contacts	YES	NO
Blurred or double vision	YES	NO
Glaucoma	YES	NO

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	YES	NO
Earaches or drainage	YES	NO
Chronic sinus problem or rhinitis	YES	NO
Nose bleeds	YES	NO
Mouth sores	YES	NO
Bleeding gums	YES	NO
Bad breath or bad taste	YES	NO
Sore throat or voice change	YES	NO
Swollen glands in neck	YES	NO

CARDIOVASCULAR

Heart trouble	YES	NO
Chest pain or angina pectoris	YES	NO
Palpitation	YES	NO
Shortness of breath with walking or lying flat	YES	NO
Swelling of feet, ankles or hands	YES	NO

RESPIRATORY

Chronic or frequent coughs	YES	NO
Spitting up blood	YES	NO
Shortness of breath	YES	NO
Asthma or wheezing	YES	NO

GASTROINTESTINAL

Loss of appetite	YES	NO
Change in bowel movements	YES	NO
Nausea or vomiting	YES	NO
Frequent diarrhea	YES	NO
Painful bowel movement or constipation	YES	NO
Rectal bleeding or blood in stool	YES	NO
Abdominal pain or heartburn	YES	NO
Peptic ulcer (stomach or duodenal)	YES	NO

PSYCHIATRIC

Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression	YES	NO
Insomnia	YES	NO

MUSCULOSKELETAL

Joint pain	YES	NO
Joint stiffness or swelling	YES	NO
Weakness of muscles or joints	YES	NO
Muscle pain or cramps	YES	NO
Back pain	YES	NO
Cold extremities	YES	NO
Difficulty walking	YES	NO

INTEGUMENTARY (Skin, Breast)

Rash or itching	YES	NO
Changes in skin color	YES	NO
Change in hair or nails	YES	NO
Varicose veins	YES	NO
Breast pain	YES	NO
Breast lump	YES	NO
Breast discharge	YES	NO

ENDOCRINE

Glandular or hormone problem	YES	NO
Thyroid disease	YES	NO
Diabetes	YES	NO
Excessive thirst or urination	YES	NO
Heat or cold intolerance	YES	NO
Skin becoming dryer	YES	NO
Change in hat or glove size	YES	NO

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts	YES	NO
Bleeding or bruising tendency	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Past transfusions	YES	NO
Enlarged glands	YES	NO

GENITOURINARY

Frequent urination	YES	NO
Burning or painful urination	YES	NO
Blood in urine	YES	NO
Change in force/strain when urinating	YES	NO
Incontinence or dribbling	YES	NO
Kidney stones	YES	NO
Sexual difficulty	YES	NO
Male - testicular pain	YES	NO
Female - pain with periods	YES	NO
Female - irregular periods	YES	NO
Female - vaginal discharge	YES	NO
Female - number of pregnancies	#_____	
Female - number of miscarriages	#_____	
Female - date of last pap smear	_____	