

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 1 st 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	_____	