INDEPENDENCE
PROSTHETICS - ORTHOTICS, INC.

Patient Information

Patient Name: _____ **Male | Female** Date of Birth: _____

SS# _____ E-Mail Address: _____

Home Address: _____

_____

Home Phone: _____ Cell Phone: _____ Other: _____

Is it ok to contact you by phone:* **YES | NO
Is it ok to leave a message at the number(s) you provided?:* **YES | NO
Is it ok to send/receive medical history to/from referring and primary care physicians?* **YES | NO

Emergency Contact
Name: _____ Relation:_____ Phone: _____

Is it okay to discuss personal information with your emergency contact?* **YES | NO

Insurance
Primary Insurance: _____ Policy Holder: _____ Subscriber DOB: _____

Secondary Insurance: _____ Policy Holder: _____ Subscriber DOB: _____

Responsible Party (if patient is a minor)
Name: _____ DOB: _____

Address: _____ Relationship: _____

Is this a Workman's Comp or Auto Accident Claim? YES | NO
The Section Below is for Workman's Compensation or Auto Accident only

Insurance Name: _____ Accident Date & State: _____ Claim #: _____

Adjuster Contact: _____ Phone Number: _____

Claims Address: _____

Description of Accident: _____

Patient (or Guardian) Signature: _____ **Date:**_____

Turn over to complete Medical History – Self-Assessment►

Medical History – Patient Self-Assessment

Patient Name: _____ Date: _____

Weight: _____ Height: _____ General Overall Health: **Poor | Fair | Good | Excellent**

Have you received any orthotics, prosthetics or back braces within the past 5 years? **Yes | No**

If **YES**, list item and date: _____

If **YES**, list opinion/problem with item: _____

Reason for Visit: _____

Referring Physician: _____ Last Visit: _____

Primary Care Physician: _____

Do you participate in Physical Therapy: **YES | NO** If **YES**, where and how often _____

Please indicate your current medical conditions:

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Vascular Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Amputation
- ☐ Hepatitis A or B
- ☐ Hepatitis C
- ☐ HIV Positive
- ☐ Rheumatoid Arthritis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Pulmonary Disease
- ☐ Allergies: _____
- ☐ Vision Problems
- ☐ Parkinson Disease
- ☐ Alzheimer Disease
- ☐ Psychiatric Problems
- ☐ Alcoholism
- ☐ Hearing Loss
- ☐ Pregnant
- ☐ Other: _____

_____

Do you require an assistive device? **Cane** | **Walker** | **Wheelchair** | **None**

Have you had surgery within the last 5 years? **YES** | **NO** If **YES**, Date: _____
Description of Procedure: _____

Do you require assistance for Activities of Daily Living? (i.e. dressing, eating, transportation) **YES | NO**

Please Rate Your Pain 1-10: (No Pain) **1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10** (Most Pain)

Is your pain: **Long Lasting | Short Time | Constant | Random**

What type of work / hobbies / activities do you do? _____

_____

What are your specific functional goals? _____

_____