INDEPENDENCE
PROSTHETICS - ORTHOTICS, INC.

Patient Information Form

Patient Name_____ Date of Birth_____/_____/_____ **M | F**

SSN_____-_____-_____ E-Mail_____

Home Address_____

Primary Phone_____ *Contact type:* **HOME | MOBILE | WORK | OTHER**_____

**Is it OK to contact you by phone? YES | NO*

**Is it OK to contact you by email? 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*

Marital Status **Single** | **Married** | **Divorced** | **Widowed** | **Other**

Employment Status **Employed** | **Unemployed** | **Retired** | **On Diability** | **On Leave of Absence** | **Student** | **Pediatric Patient**

Emergency Contact

Name_____ Relation_____ Phone_____

Please specift emergency contact's phone number type:* **HOME | MOBILE | WORK | OTHER_____

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

Responsible Party/Parent/Gaurdian (only if patient is under 18 years of age)

Name_____ Relation_____ Phone_____

Address_____

Insurance

Primary_____ Policy Holder_____ Subscriber DOB_____

Secondary_____ Policy Holder_____ Subscriber DOB_____

Is this a Workman's Comp or Auto Accident Claim? YES | NO **Below Workman's Compensation or Auto Accident only*

Insurance Name_____ Accident Date & State_____ Claim #_____

Adjuster's Name_____ Phone Number_____

Claims Address_____

Patient (or Guardian) Signature_____ **Date**_____

Please turn over to complete Medical History Form ⟶

Medical History Form

Patient Name _____ Weight _____lbs. Height _____'_____" Shoe Size_____

General Overall Health: **Poor | Fair | Good | Excellent** Reason for visit today: _____

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_____

Referring Physician_____ Last Visit_____

Primary Care Physician_____ Last Visit_____

Do you participate in Physical Therapy: **Yes | No**

If **YES**, where and how often: _____

Since your last visit, has any of your information changed? If so please notify administration and circle: **Yes | No**

If **YES**, please circle: **Insurance** | **Address** | **Phone Number(s)** | **Other (please specify)** _____

Please indicate your current medical conditions:

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

Do you use an assistive device to help you ambulate? **None | Cane | Walker | Wheelchair**

Have you had surgery within the last 5 years, relevant for your visit today? **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 participate in? _____

_____

What are your specific functional goals? _____

_____