INDEPENDENCE
PROSTHETICS - ORTHOTICS, INC.

Patient Information Form

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

SS# _____ E-Mail: _____

Home Address: _____

_____

Home Phone: _____ Cell Phone: _____

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**

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**

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

Secondary: _____ 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: _____

How did you hear about us? **Referring Physician** | **Internet** | **Family** | **Friend** | **Other**: _____

Please list family/friend who referred you so we can acknowledge them? _____

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

Please turn over to complete Medical History Self-Assessment ⟶

Medical History Patient Self-Assessment 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? _____

_____