ORTHOPEDIC SPECIALTY INSTITUTE™

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BOARD-CERTIFIED PLASTIC & RECONSTRUCTIVE SURGEON
1875 N Lakewood Drive, Suite 200 | Coeur d'Alene, Idaho 83814

HAND & WRIST INTAKE FORM | PERSONAL DEMOGRAPHIC INFORMATION

NAME: _____ DATE: _____
LAST FIRST MIDDLE

S.S.N. ☐☐☐ ☐☐ ☐☐☐☐ BIRTH DATE: / / AGE: GENDER: M / F

MAILING ADDRESS: _____
STREET CITY STATE ZIP CODE

PHONE: _____ _____ EMAIL ADDRESS: _____
HOME CELL

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ WIDOWED

SPOUSE (IF APPLICABLE): _____
NAME BIRTH DATE

PREFERRED LANGUAGE: ☐ ENGLISH ☐ OTHER _____

RACE: ☐ AMERICAN-INDIAN ☐ BLACK/AFRICAN-AMERICAN ☐ WHITE ☐ OTHER _____ ☐ DECLINED

ETHNICITY: ☐ CENTRAL-AMERICAN ☐ HISPANIC / LATINO / SPANISH ☐ OTHER _____ ☐ DECLINED

INSURANCE INFORMATION

PRIMARY INSURANCE COVERAGE:

_____ _____ _____
NAME OF CARRIER POLICY NUMBER GROUP NUMBER

_____ _____ _____
SUBSCRIBERS NAME & PATIENT RELATIONSHIP SUBSCRIBER D.O.B. INSURANCE PHONE NUMBER

SECONDARY INSURANCE COVERAGE:

_____ _____ _____
NAME OF CARRIER POLICY NUMBER GROUP NUMBER

_____ _____ _____
SUBSCRIBERS NAME & PATIENT RELATIONSHIP SUBSCRIBER D.O.B. INSURANCE PHONE NUMBER

GUARANTOR INFORMATION (IF UNDER 18) : _____ _____
NAME PHONE

EMPLOYMENT INFORMATION: _____
EMPLOYER'S NAME ADDRESS

_____
PATIENT NAME

CONTINUED ON NEXT PAGE ➔

PATIENT INFORMATION, CONTINUED

1. HOW DID YOU LEARN ABOUT US, OR WHO REFERRED YOU TO THE ORTHOPEDIC SPECIALTY INSTITUTE™

INFORMATION SOURCE OR NAME OF REFERRER _____ PHONE _____

2. WHO IS YOUR PRIMARY CARE PHYSICIAN?

NAME OF PHYSICIAN _____ PHONE _____

STREET _____ CITY _____ STATE _____ ZIP _____

3. WHAT PHARMACY DO YOU USE?

NAME OF PHARMACY _____ PHONE _____

STREET _____ CITY _____ STATE _____ ZIP _____

ARE YOU CURRENTLY TAKING ANY NARCOTICS? ☐ YES ☐ NO IF YES, NAME? _____ HOW LONG? _____

I agree the **Orthopedic Specialty Institute™** may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE: _____

6. PLEASE LIST ALL MEDICATIONS / HERBS / TEAS YOU CURRENTLY USE:

TYPE / NAME _____ FREQUENCY _____ DOSAGE _____

TYPE / NAME _____ FREQUENCY _____ DOSAGE _____

TYPE / NAME _____ FREQUENCY _____ DOSAGE _____

7. DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST AND DESCRIBE YOUR REACTION TO THE MEDICATION:

MEDICINE ALLERGY _____ REACTION _____

PATIENT NAME _____

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PATIENT INFORMATION, CONTINUED

8. ARE YOU CURRENTLY OR HAVE YOU EVER HAD PROBLEMS WITH THE FOLLOWING?

	YES	NO		YES	NO
No Past Medical problems reported			Liver Disease		
Anxiety Disorder			Low Back Pain		
Arthritis: Type?			Neck Pain		
Asthma			Mid Back Pain		
Bleeding Disorder			Radiculopathy — Upper		
Blood Clots (Deep Vain Thrombosis)			Radiculopathy — Lower		
Cancer: Type?			Organ Transplant		
CHF			Osteopenia		
Claustrophobic			Osteoporosis		
Coronary Artery Disease			Other Lung Disease		
COPD			Poliomyelitis		
Diabetes Type I			Peripheral Vascular Problem		
Diabetes Type II			Pulmonary Embolism		
Dialysis			Reflux Disease		
Diverticulitis			Rheumatoid Arthritis		
Fibromyalgia			Sciatica		
Gout			Stroke		
Pacemaker			Tuberculosis (TB)		
Heart Arrhythmia			Ulcers		
Heart Attach (MI)			Urinary Tract Infection		
Heart Murmur			Other:		
Hiatal Hernia			Problems with Anesthesia		
HIV or AIDS			Hepatitis		
Hypertension			Hypercholesterolemia		
Hyperthyroidism			Leg / Foot Ulcers		
IBS (Irritable Bowel Syndrome)			Kidney Disease		
Kidney Stones					

9. ARE YOU ALLERGIC TO LATEX OR TAPE? ☐ YES ☐ NO

10. HAVE YOU EVER HAD MRSA? ☐ YES ☐ NO

11. HAVE YOU EVER HAD HEPATITIS C or B? ☐ YES ☐ NO

12. DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MANY DRINKS/WEEK? _____

13. DO YOU SMOKE? ☐ YES ☐ NO IF YES, PACKS/DAY? _____ HOW LONG? _____

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_____
PATIENT NAME

PATIENT INFORMATION, CONTINUED

14. PLEASE ANSWER THE FOLLOWING QUESTIONS: DO YOU . . .

HAVE CHILDREN? ☐ YES ☐ NO IF YES, HOW MANY? _____ TYPE OF DELIVERY? _____

LIVE ALONE? ☐ YES ☐ NO IF NO, WITH WHOM? _____

USE A SPECIAL DIET? ☐ YES ☐ NO DESCRIBE _____

USE RECREATIONAL DRUGS? ☐ YES ☐ NO DESCRIBE _____

EXERCISE REGULARLY? ☐ YES ☐ NO HOW OFTEN? _____

SPORTS OR HOBBIES? ☐ YES ☐ NO DESCRIBE? _____

15. PLEASE LIST ALL PAST SURGERIES AND HOSPITALIZATIONS:

SURGERY / HOSPITALIZATION	DATE	PHYSICIAN / SURGEON

16. HAVE YOU EVER HAD PROBLEMS WITH GENERAL ANESTHESIA? ☐ YES ☐ NO

17. FAMILY HISTORY

FAMILY MEMBER	IF ALIVE, AGE & HEALTH STATUS	IF DECEASED, AGE AT TIME OF DEATH & CAUSE
FATHER		
MOTHER		
SIBLING		
SIBLING		
AUNTS		
UNCLES		

PATIENT NAME

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PATIENT INFORMATION, CONTINUED

18. CURRENT VITALS:

HEIGHT _____ WEIGHT _____ BRA SIZE _____

19. CHIEF COMPLAINT / CURRENT CONCERN:

Which side is your chief complaint or concern? ☐ LEFT ☐ RIGHT

Describe your chief complaint or concern: _____

_____

How long have you had this problem? _____

Is your problem getting: ☐ WORSE ☐ BETTER ☐ STAYING THE SAME

Was this a result of an injury? ☐ YES ☐ NO IF YES, WHAT WAS THE DATE OF THE INJURY? _____

If yes, please describe how it happened? _____

_____

19. WORK-RELATED INJURY:

Job Title: _____

How long have you worked for this employer?

Date of Injury: ____/____/____ _____

Are you: ☐ OFF WORK ☐ MODIFIED DUTY ☐ FULL DUTY

If you are not working full duty, what date did you last do so? ____/____/____

20. IF PAIN IS ONE OF YOUR COMPLAINTS, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Rate the average intensity of your pain / discomfort. (0=No Pain ; 10=Severe Pain)

1 2 3 4 5 6 7 8 9 10

Describe your pain:

☐ INTERMITTENT ☐ CONSTANT ☐ DULL ☐ SHARP

☐ TIGHT ☐ BURNING ☐ THROBBING ☐ TINGLING

PATIENT NAME

CONTINUED ON NEXT PAGE ➔

PATIENT INFORMATION, CONTINUED

21. TIMING

Is your pain worse at any particular time of the day? ☐ MORNING ☐ EVENING ☐ NIGHT

Does your hand/wrist allow you to sleep comfortably? ☐ YES ☐ NO

22. ACTIVITY-RELATED SYMPTOMS:

	YES	NO	If YES, please describe
Stiffness			
Numbness			
Tingling			
Swelling			
Weakness			
Pain			
Other			

22. HAVE YOU TRIED ANY OF THE BELOW? RELIEF OF SYMPTOMS?

Medication ☐ YES ☐ NO Type? _____

Therapy? ☐ YES ☐ NO If yes, how long did you attend? _____

When was your last session? ____/____/____

Injections? ☐ YES ☐ NO If yes, location and medicine? _____

Other ☐ YES ☐ NO Describe: _____

_____ I acknowledge that I have received the **Notice of Privacy Practices** of the Orthopedic Specialty Institute,™ which explains its legal duties and privacy practices with respect to my protected health information.

By signing below, I agree that all the information provided is true to the best of my knowledge. I also hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for the non-covered services. I also authorize the physician to release any information required to process this claim.

PATIENT SIGNATURE _____ DATE _____

I have reviewed the above information in detail with the patient.

KATE KUHLMAN-WOOD, MD _____ DATE _____

PATIENT NAME _____