ORTHOPEDIC PARTNERS

New Foot/Ankle Intake Form

Name:_________________________________ **DOB:** ___________ **Date:**___________________________

Employer:_____________________________ **Current Occupation/Job**________________________

Activities, Hobbies____

Please Describe Your Bone/Joint Problem, Which Side It Is On, And How We Can Help: _________________
____
____

Date Problem Began:___________________________ **Reported to employer?** **Yes** **No**

Result of Injury? **Yes** **No** **Involves a Legal Case?** **Yes** **No**

Happen at Work? **Yes** **No** **Date:**__________ **Have you worked Since?** **Yes** **No**

Last Day worked? _____________________________

You are here today with: Alone Spouse Parent Child Sibling Friend Relative Interpreter Case Manager

Normally live with: Alone Spouse Parent Child Sibling Friend Relative

What is your domicile status? House Apartment Rehab Center Nursing Home Assisted Living

Is your typical shoe-wear? Sneakers Sandals Heels Diabetic Wear SAS Loafers Dress Other

Current Work Status: Full Duty Light Duty Unemployed Retired Permanently Disabled
Weight Bearing Status on affected side: non touchdown partial full

Immobilization: none post-op shoe sleeve/stirrup boot splint toe protector cast AFO Custom Brace

Assistive device: none crutches walker wheelchair cane other

Driving Status: Yes No

Pain Location: ____
Level, currently (indicate on scale): (no pain) 0—1—2—3—4—5—6—7—8—9—10(worst pain imaginable)

Improves with: rest activity heat cold elevation massage shoe-wear removal NSAIDS nothing

Timing: during activity after activity never sometimes always standing sitting nighttime unpredictable

Description: sharp dull burning constant intermittent infrequent gradual sudden improving worsening

Do you Have Instability? Yes No
How Many Yards can you walk Without Stopping? ________ **With Stopping**? __________

You are currently able to: stand walk jog run jump climb cycle play sports wear shoes go outside

Have you EVER had any of the following treatments/tests for THIS problem (check all that apply):

_____Orthotics
____Cast Immobilization
____Bracing (e.g., boot, stirrup, lace-up, splint, toe protector)
____Injection
____Physical Therapy
____PAST SURGERY: 1. Type:___________________________Date:____________Surgeon:_____________Helped?____

2. Type:___________________________Date:____________Surgeon:_____________Helped?____

____X-rays
____MRI
____Cat Scan
____EMG/Nerve Study
____Bone Scan

DX:____________________________________RX:______________________________XR/Date:______________________

ORTHOPEDIC PARTNERS

Date: ___________________________ Date of Injury: _____________________

Patient: _________________________ Place of Injury: ____________________

Provider: ________________________ Work Related? _____ Yes / ______ No

Account #: _______________________ Auto Accident: _____ Yes / ______ No

Insurance: _______________________ ID: _____________________________

Subscriber: ______________________

If your care is the result of an auto accident, please check one of the below:

_____ I have Med Pay on my Auto Policy
(this means the auto insurance pays as your primary insurance)

______I have no Auto Med Pay Insurance
(this means personal health insurance pays as your primary insurance. Please supply a statement from your auto carrier that there was no med pay effective at time of the accident)

Are you pursuing legal action against another party? _____ Yes / ______ No

What did you injure? (example: left arm) _____________________________

Attention Pequot Plus members: if your injury is the result of an auto accident and you were the driver, Pequot Plus requires that you submit a copy of the police report to their office.

Give a complete and accurate account of the injury, including <u>how</u> and <u>where</u> it occurred as required by your insurance:

____

____

____

Signature ____ Witnessed ___________________________