



Kelsey DePriest PA-C Intake Form

Name: _____ DOB: _____ Date: _____

Referred by Doctor: _____, friend or family

Age: _____ Which hand do you write with? L/R Sex: M/F

Occupation: _____

Current work status: Full duty / light duty / disabled / retired

Chief Complaint? _____

Date of Onset? _____

Result of Injury? Yes / No If Yes, how did it happen (briefly) _____

Happen at work? Yes / No Reported to Work? Yes / No Legal Care? Yes / No

Symptoms Improved with (circle all that apply) rest, heat, ice, NSAIDS, narcotics, physical/occupation therapy, splints, nothing, other _____

Symptoms made worse by (circle all apply) lifting, pushing, pulling, sleeping, driving, vibratory equipment, weather, nothing, other _____

Description of symptoms (circle all that apply) Numbness, burning, sharp, dull, ache, radiating, other _____

What have you tried for this problem? PT/OT, Splints, injections, surgery, other _____

For the body part you are being seen for today have you had? If so, what facility were they done at?

Xrays, MRI, Ct scan, EMG, other tests _____



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 how and where it occurred as required by your insurance:

Signature _____ Witnessed _____

(860) 889-7345

(860) 963-2133

82 New Park Avenue
North Franklin, CT 06254

11 Industrial Park Road
Niantic, CT 06357

35 Kennedy Drive
Putnam, CT 06260

5 Founders Steet
Willimantic, CT 06226