

**John G. Atwater, M.D.
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To Best Serve You Please Complete This Form and Carry It To Your Appointment.

PATIENT'S NAME		SOC. SECURITY #		TODAY'S DATE
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MARITAL STATUS		DATE OF BIRTH	SEX		AGE	HOME PHONE & AREA CODE
S	M		W	D		

ADDRESS		CITY, STATE, ZIP		OTHER PERSONAL PHONE # (ie. Cellular)
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EMPLOYER'S

NAME: _____ ADDRESS: _____ PHONE: _____

RESPONSIBLE PARTY'S

NAME: _____ SOC. SECURITY#: _____ DATE OF BIRTH: _____

EMPLOYER OF RESPONSIBLE PARTY

NAME: _____ ADDRESS: _____ PHONE: _____

PHYSICIAN WHO REFERRED YOU :

PRIMARY CARE PHYSICIAN

NAME: _____ ADDRESS (CITY, STATE & ZIP) _____

HAVE YOU EVER BEEN TREATED BY ANOTHER PHYSICIAN AT McLEAN COUNTY ORTHOPEDICS? IF SO, WHAT YEAR?

PRIMARY INSURANCE COMPANY (MEDICARE, IDPA, SELF EMPLOYED, PRIVATE, ETC)

ADDRESS	GROUP NUMBER	POLICY NUMBER
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SECONDARY INSURANCE COMPANY (MEDICARE, IDPA, SELF EMPLOYED, PRIVATE, ETC)

ADDRESS	GROUP NUMBER	POLICY NUMBER
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The undersigned authorizes McLean County Orthopedics, Ltd. to release and/or obtain information in the course of treatment regarding medical condition of the patient to the previously named Insurance Company(s) and Physician(s).

The undersigned also authorizes that medical benefit payments be made directly to McLean County Orthopedics, Ltd. for this care to the extent of the patient's bill without necessity of their name being on the check or draft.

In order to control our costs of billing, we request that office visits be paid at the time service is rendered. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred. The undersigned also agrees to be responsible for a finance charge of 1½ % per month on any unpaid balance.

Date: _____ Signature _____

DID AN INJURY CAUSE OR AGGRAVATE YOUR PROBLEM?	CAUSED	AGGRAVATED	NO INJURY
WHEN WAS THE FIRST OR MOST SERIOUS INJURY?			
PLEASE DESCRIBE THE INJURY: _____			

IS THIS A WORK INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WORK COMP INSURANCE NAME:	ADJUSTERS PHONE #:
WORK COMP NURSE MANAGER NAME:	PHONE #:

IS THIS A LIABILITY CLAIM (ie. Car Accident)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
LIABILITY INSURANCE NAME:	CLAIM #:
LIABILITY INSURANCE ADDRESS	
INSURANCE CONTACT PERSON? NAME:	PHONE #:

WHAT IS YOUR MAIN SYMPTOM (Please indicate left or right side)? _____

LIST ANY SURGERIES YOU HAVE HAD IN RELATION TO THIS PROBLEM (INCLUDE DATE/TYPE):

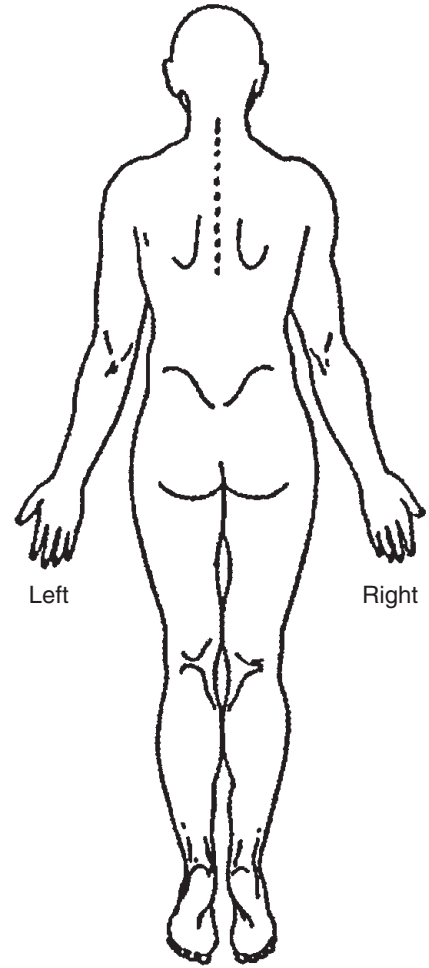
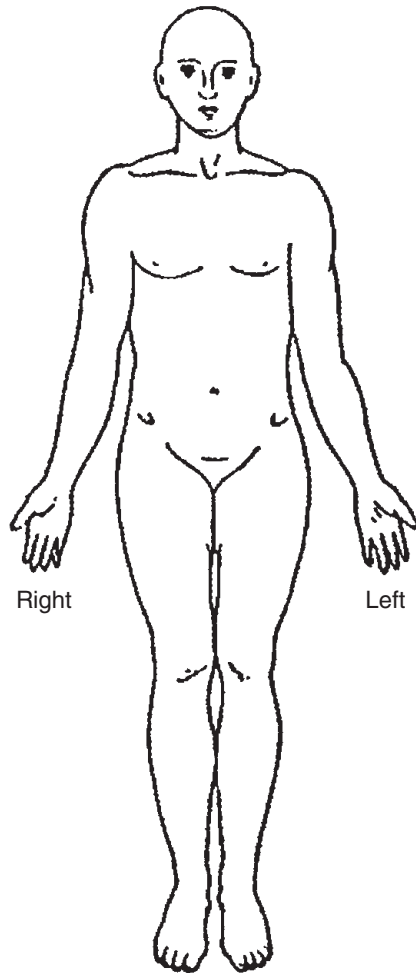
LIST THE DATE THIS PROBLEM STARTED AND A BREIF HISTORY OF EVENTS:

CURRENT SYMPTOMS

NUMBNESS / TINGLING? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, WHERE DO YOU FEEL NUMBNESS / TINGLING?
WEAKNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, WHERE DO YOU FEEL WEAK (PLEASE NOTE WHICH SIDE OF THE BODY)? SHOULDER ELBOW WRIST HAND HIP KNEE ANKLE
WHAT AGGRAVATES YOUR PAIN (CIRCLE ALL)? Bending Forward Bending Backward Sleeping On Your Side Sleeping On Your Back Sitting Standing Walking Raising Arms Above Head Bending Your Neck Other: _____	
WHAT IMPROVES THE PAIN (CIRCLE ALL)? Heat Ice Rest Sitting Lying Down Medication Other: _____	

PLEASE MARK WHERE YOU FEEL PAIN (USE THE SYMBOLS BELOW):

Stabbing = / / / / Burning = x x x x Deep Ache = z z z z Pins & Needles = o o o o
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WHAT TREATMENTS HAVE YOU TRIED FOR THIS PROBLEM?

TREATMENT	WHEN WAS IT TRIED?	HOW MUCH DID IT HELP?
PHYSICAL THERAPY		
TRACTION		
TENS UNIT		
CHIROPRACTIC MANIPULATION		
ACCUPUNCTURE		
EPIDURAL INJECTION		
FACET INJECTION		
OTHER INJECTION _____		
NECK/BACK BRACE		
PSYCHOLOGICAL COUNSELING		
PREDNISONE OR MEDROL		

REVIEW OF SYSTEMS:

ARE YOU HAVING ANY OF THE FOLLOWING:			
Chest Pain		Shortness of Breath	
Blood in Urine, Sputum, or Stool		Severe Constipation	
WEIGHT LOSS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, HOW MUCH WEIGHT LOSS?	HOW LONG HAVE YOU BEEN LOSING WEIGHT?	
NIGHT SWEATS? <input type="checkbox"/> YES <input type="checkbox"/> NO	FEVERS? <input type="checkbox"/> YES <input type="checkbox"/> NO	CHILLS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
BLADDER INCONTINENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	BOWEL INCONTINENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	CHANGE IN BLADDER FUNCTION? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES PAIN INTERFERE WITH SLEEP? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, HOW MUCH SLEEP DO YOU GET EACH NIGHT? _____ HOURS		
HISTORY OF CANCER? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, WHICH TYPE?		
ANY EVIDENCE OF REMAINING CANCER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
HOW FAR CAN YOU WALK? Unlimited 1 mile 4 blocks 2 blocks 1 block 50 feet 10 feet None		WALKING IS LIMITED BY? Pain Weakness Other:	

SOCIAL HISTORY

DRUG OR ALCOHOL ABUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO		MIGHT YOU BE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU USE TOBACCO? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF SO, HOW LONG?	HOW MANY PACKS PER DAY?
DID YOU PREVIOUSLY USE TOBACCO? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF SO, HOW LONG?	HOW MANY PACKS PER DAY?
ARE YOU STILL COLLECTING SOCIAL SECURITY DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		SOCIAL SECURITY START DATE?	
CURRENT WORK STATUS? Working Disabled Unemployed Retired Sick Leave		ARE YOU ON WORK RESTRICTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHAT TYPE OF WORK DO YOU DO?		DOES YOUR JOB CONTRIBUTE TO YOUR PAIN? <input type="checkbox"/> YES <input type="checkbox"/> NO	

HEIGHT (APPROXIMATE)?	WEIGHT (APPROXIMATE)?
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WHAT TESTS HAVE YOU HAD FOR THIS PROBLEM?

Test	Date(s)	Where Was the Test? (IE. BROMENN)
CT		
MRI		
X-RAY		
EMG		
MYELOGRAM		
BONE SCAN		
BONE DENSITY		
OTHER:		

THANK YOU FOR COMPLETING THIS FORM!