



Dr. Ellingsen's New Patient Form

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Account #: _____

Referring MD: _____

Height: _____ Weight: _____

Respirations: _____

Medications: _____

Allergies: _____

Current Problem: _____



Dr. Ellingsen's New Patient Form

DATE: _____

ACCT #: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Are you employed? Yes No Employer's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact (not living with you): _____ Telephone #: _____

Address: _____ City: _____ State: _____ Zip: _____

SPOUSE/PARENT INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Are you employed? Yes No Employer's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

ALL PATIENTS: PLEASE FILL OUT HEALTH INSURANCE SECTION

Health Insurance Company: _____ ID#: _____

Secondary Insurance Company: _____ ID#: _____

IS THIS WORKER'S COMP? IF SO, PLEASE COMPLETE:

Employers _____ Name of W/C Carrier _____

Address: _____ Address: _____

Telephone: _____ Telephone: _____

Date of Accident: _____ Claim#: _____ Adjuster Name: _____

IS THIS AUTO? IF SO, PLEASE COMPLETE:

Name of Auto Insurance Co.: _____ Telephone: _____

Claim Office Address: _____ Claim/Policy: _____

_____ Date of Accident: _____

NOTICE

Interest may be charged on all accounts which are transferred to collections at a rate of 1 1/2% per month, annual rate of 18%. I understand that interest charges will be added to any account I have that is 90 days or more past due and hereby agree to pay such charges it levied

Signature: _____ Date: _____

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PATIENT HISTORY
Please PRINT and fill out completely

Name: _____ Today's date: _____
Age: _____ Height: _____ Weight: _____ Hand Dominance Left Right

HISTORY OF INJURY

Did the problem result from a specific injury? Yes No Injury/Accident date: _____

Did your problems begin following: Work Injury? Motor Vehicle Accident? What State? _____

How did you get injured? _____

If neither, how long have you had the condition? _____

Please rate your pain on a scale of 1 to 10 (10 being the most painful): _____

Is the pain: Constant Occasional Sharp Dull Aching Stabbing Throbbing

What symptoms are you experiencing: Locking Catching Giving Way Popping Grinding Other

What, if anything, makes you symptoms better? _____

What, if anything, makes you symptoms worse? _____

Have you seen another physician for this injury? Yes No

If yes, who? _____

What treatments have you tried? Nothing Physical Therapy Exercise Acupuncture

Chiropractic Injections (specify: ESI, Facets, Sacroiliac, Selective Nerve Root Block, Synvisc, Hyalgan)

Medications _____ Other: _____

Test	Date (month/year)	What facility? (clinic/hospital)
<input type="checkbox"/> X-ray	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Other	_____	_____

Regular Exercise. Yes No Type of exercise and activity you enjoy: _____

PAST SURGICAL HISTORY

Please check any previous surgical procedures, list the date and describe surgery:

Appendectomy Hernia repair Arthroscopy lower extremity Upper extremity
 Spine/Back surgery Heart surgery Total Joint Replacement Fracture Repair

Other: _____



Dr. Ellingsen's New Patient Form

Health History - page 2

Name: _____ Practitioner's Initials: _____

SOCIAL HISTORY

Special Diet: Yes No Any Restrictions? _____
 Tobacco Use: Yes No Type: _____ Duration _____ Quit Date _____
 Alcohol Use: Yes No Frequency: _____
 Drug Use: Yes No Frequency: _____
 Caffeine Use: Yes No Frequency: _____

ALLERGIES

Are you allergic to any medications? Yes No NO KNOWN DRUG ALLERGIES
 Are you allergic to: Sulfa Yes No Latex Yes No
 Please list all medications that you are allergic to: _____

MEDICAL HISTORY

Please check current or previous medical conditions:

- Anemia
- Arthritis
- Asthma
- Blood Clots
- Cancer
- Other _____
- Depression
- Diabetes
- Emphysema
- Heart Disease
- Liver Disease
- Hepatitis A or B
- High Blood Pressure
- HIV
- Irregular Heartbeat
- Chemical Dependency and/or Alcoholism
- Osteoporosis
- Rheumatoid Arthritis
- Stroke/Seizures
- Thyroid

Have you ever had a blood transfusions? Yes No If yes, when? _____

MEDICATIONS

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any other the counter medications. Include Vitamin, Mineral and Herb supplements.

<i>Medication</i>	<i>Dosage</i>	<i>Frequency</i>

GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? Yes No If yes, when? _____
 Do you have a history of GI, stomach bleed? Yes No If yes, when? _____
 Do you take any medications for your stomach? Yes No (Please include over the counter medications, i.e. Pepcid, Tums, Zantac, etc., dosage and frequency.) _____

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? (Please include over the counter medications such as Advil, Aleve and previously prescribed medications, such as Celebrex and Vioxx. List all you have tried.)



Dr. Ellingsen's New Patient Form

Health History - page 3

Name: _____

Practitioner's Initials: _____

FAMILY HISTORY Please check family history conditions:

- | | | | |
|--------------------------------------|--|---------------------------------------|---|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke/Seizures |

Please describe any immediate family history of medical problems: _____

REVIEW OF SYSTEMS

Check if you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have any problems, please check the "NONE" box.

- | | | | | | |
|-------------------------------|---|--|---|--|--|
| 1. Constitutional/
General | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Chronic Fatigue |
| 2. Eyes | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Vision Change | <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| 3. Ears, Nose,
Throat | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Sinus pain | <input type="checkbox"/> Ringing |
| 4. Cardiovascular | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Edema | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Palpitations |
| 5. Respiratory | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Asthma | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Frequent Cough | |
| 6. Gastrointestinal | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Heart Burn
<input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Indigestion
<input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Acid Reflex
<input type="checkbox"/> GI, Stomach Bleed | <input type="checkbox"/> Ulcer Problems |
| 7. Musculoskeletal | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Back Pain |
| 8. Skin | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Rash | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Scars | |
| 9. Neurological | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures | <input type="checkbox"/> Numbness | <input type="checkbox"/> Dizziness |
| 10. Psychiatric | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Depression | <input type="checkbox"/> Crying | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mood Swing |
| 11. Endocrine | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Hot flashes |
| 12. Hematology | <input type="checkbox"/> NONE
<input type="checkbox"/> OTHER | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Anemia | |

Signature: _____

Date: _____

Print Name: _____