

Patient Name:
D.O.B: Age:
Date:



Name: DOB: SS#:
Address: City: State: Zip Code:
Home#: Work#: Cell#:
Marital Status: Sex: Email:
Employer: Employer Address:

Guarantor Name (if not self):

Guarantor Address:

Guarantor Phone: Guarantor DOB: SS#:

Emergency Contact Name: Phone:

Primary Insurance:

Policy Number: Group #:

Name of Subscriber: Relation to Patient:

Policy Holder's DOB: Policy Holder's SS#:

Secondary Insurance:

Policy Number: Group #:

Name of Subscriber: Relation to Patient:

Policy Holder's DOB: Policy Holder's SS#:

Who referred you to our office? Phone #:

Who is your Primary Care Physician? Phone #:

What Pharmacy do you use? Phone #:

Additional Information:

Race _____ Ethnicity _____ Preferred Language _____

Please Initial the below policies and sign below.

Authorization to treat: Initial _____ **Medicare Long-term Authorization:** Initial _____

Medigap Authorization: Initial _____ **Form Completion Policy:** Initial _____

Financial Policy: Initial _____

HIPPA Email Authorization: _____ I consent _____ I do not consent

Patient Responsibility Agreement for Controlled Substance Prescriptions: Initial _____

Telemedicine Informed Consent: Initial _____

Notice of Privacy Practices Receipt: Initial _____

I was made aware that a printed copy of these policies is available upon request for my record. I have read and understood all policies and procedures.

Patient Signature: _____ **Date:** _____

Patient Name:
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HIPAA Authorization to Release Medical Information

Due to HIPAA Regulations and our promise to provide you with the utmost privacy, this HIPAA Authorization to Release Medical Information Form is designed to allow only certain people whom you select to have access to your medical information. (For example: your spouse, children, or family friend (this form only pertains to family and friends)). **I hereby authorize the following people to have access to my medical information:**

(This includes but is not limited to sitting in during my consultations with the physician and calling the office to check my medical status. This authorization will hold in effect until I submit a written notice of any changes.)

Name	Relationship	Phone Number	Authorization Date
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Patient Signature: _____

Our office utilizes an automated appointment system and we would like to include you if interested in receiving appointment reminders.

Yes, I am interested _____ **(Please check)**

I would prefer TEXT (SMS) _____ VOICE CALLS _____

Please update your contact information:

Home phone: _____

Cell phone: _____

No, I am not interested in receiving automated appointment reminders. I would prefer the office staff to call me.

_____ **(Please check)**

Thank you for taking time to complete this form.

Patient Name:
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Date:



**Authorization to Release or Obtain Medical Records
(Signature only required)**

I, _____ DOB: _____

Authorize:

- Tru Ortho**
18626 Hardy Oak Blvd Ste. 101
San Antonio TX, 78258
(P) 210-878-4116 (F)210-878-4113

Or Other (specify below)

- Name of Person or Facility: _____
Address: _____
City: _____ State: _____ Zip: _____

To release information to:

To Obtain information from:

Name of Person of Facility: _____
Address: _____
City: _____ State: _____ Zip: _____

Purpose of this Authorization: _____

I authorize the release of the following protected health information:

(Place an "X" in the box(es) that apply to this information you want released or want to obtain)

For personal copies of your medical records the cost will be \$25.00 for the first 25 pages and .25 cents for each page thereafter.

Please allow 15 business days from day of request to process your request for medical records.

Entire record Consultation notes/report Lab reports X-Ray reports Surgical reports.

Medical History, Examination reports Treatment or Test Hospital records including reports.

Other: _____

Patient Signature: _____ **Date:** _____

Witnessed by: _____ Date: _____

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Medical History

Sex/Gender: M F Other Primary Care Physician: _____ Who referred you to our clinic? _____
 Occupation: _____ Is this work related? Yes No If work related, was it reported? Yes No
 Case manager or adjuster: _____

Current Medications: Include prescription, non-prescription medications & herbal supplements . **If you have a list, please provide.**

I give Tru Ortho permission to obtain my medication history from External Prescription history if needed.

Name of Medication or supplement	Dosage (ie. Milligrams)	How often do you take it? (ie 1 tablet daily)

<p>Allergies to Medications: Drug Name: _____ Type of Reaction _____</p> <p>_____</p> <p>_____</p>	<p>Drug Name: _____ Type of Reaction _____</p> <p>_____</p> <p>_____</p>
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Do you have any allergy or sensitivity to metal? Yes No **Have you ever had an adverse reaction to anesthesia?** yes No

Past Medical History: Have you ever had any of the following? If yes, please check boxes:

<p><u>BLOOD</u> <input type="checkbox"/> Anemia <input type="checkbox"/> Hemophilia <input type="checkbox"/> Sickle Cell <input type="checkbox"/> DVT <input type="checkbox"/> Clotting problems <input type="checkbox"/> Other: _____</p>	<p><u>INTEGUMENTARY (Skin/Nails)</u> <input type="checkbox"/> Cellulitis <input type="checkbox"/> Eczema <input type="checkbox"/> Shingles <input type="checkbox"/> Rosacea <input type="checkbox"/> Contact Dermatitis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other: _____</p>
<p><u>CANCER</u> <input type="checkbox"/> Breast <input type="checkbox"/> Liver <input type="checkbox"/> Prostate <input type="checkbox"/> Skin <input type="checkbox"/> Lung <input type="checkbox"/> Leukemia <input type="checkbox"/> Kidney <input type="checkbox"/> Ovarian <input type="checkbox"/> Colon <input type="checkbox"/> Cervical <input type="checkbox"/> Uterine <input type="checkbox"/> Other: _____</p>	<p><u>REPRODUCTIVE</u> Currently Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No LMP: _____ Currently Breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>RESPIRATORY</u> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Clot in lungs (pulmonary embolus) <input type="checkbox"/> Other: _____</p>	<p><u>PSYCHOLOGICAL</u> <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> PTSD <input type="checkbox"/> Anxiety <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Autism <input type="checkbox"/> Other: _____</p>
<p><u>INFECTIOUS DISEASE</u> <input type="checkbox"/> AIDS <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis A/B/C <input type="checkbox"/> Tuberculosis <input type="checkbox"/> MRSA/VRE (resistant org) <input type="checkbox"/> Covid 19 <input type="checkbox"/> Covid Vaccine completed <input type="checkbox"/> Other: _____</p>	<p><u>CARDIAC</u> <input type="checkbox"/> Aneurysm <input type="checkbox"/> Chest pain/angina <input type="checkbox"/> Cardiac bypass surgery <input type="checkbox"/> Pacemaker <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Other: _____</p>
<p><u>EENT (Eyes/Ears/Nose/Throat)</u> <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Hearing loss <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataract- Left <input type="checkbox"/> Cataract- Right <input type="checkbox"/> Hearing device- Left <input type="checkbox"/> Hearing device- Right <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Corrective Lenses <input type="checkbox"/> Other: _____</p>	<p><u>ENDOCRINE (Diabetes/Thyroid/Pancreas)</u> <input type="checkbox"/> DM Type I <input type="checkbox"/> DM Type II <input type="checkbox"/> Hashimoto's <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Addison's <input type="checkbox"/> Cushing <input type="checkbox"/> Graves' <input type="checkbox"/> Other: _____</p>

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MUSCULOSKELETAL (Bones/Muscles/Ligament/Tendons/Joints) <input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Chronic back pain <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Chronic neck pain <input type="checkbox"/> Gout <input type="checkbox"/> Lupus or Scleroderma <input type="checkbox"/> Other: _____	URINARY (Kidney/Bladder) <input type="checkbox"/> Prostate disease (BPH/Enlarged prostate) <input type="checkbox"/> Cystitis <input type="checkbox"/> Dialysis <input type="checkbox"/> Urinary retention <input type="checkbox"/> Kidney stones <input type="checkbox"/> Chronic renal disease <input type="checkbox"/> Incontinence <input type="checkbox"/> UTI chronic <input type="checkbox"/> Self Catherization <input type="checkbox"/> Other: _____
NEUROLOGICAL (Brain/Spinal cord) <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia <input type="checkbox"/> Parkinson's <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Stroke <input type="checkbox"/> TIA (Any residual deficits?) _____ <input type="checkbox"/> Paralysis (Quadra or Paraplegia) <input type="checkbox"/> Other: _____	GASTROINTESTINAL (Digestive/Esophagus/Stomach/Colon/Rectum) <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> GERD <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Gastrointestinal bleeding <input type="checkbox"/> Other: _____

Past Surgical History: Please list ANY past surgeries.

Date	Surgery	Surgeon	Date	Surgery	Surgeon

Hospitalizations: For surgeries Others: _____ None

Family History: Adopted None

Social History:

	Mother	Father	Sibling	Other	Unknown					
Heart/Cardiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/> No	<input type="checkbox"/> Rare	<input type="checkbox"/> Moderate	<input type="checkbox"/> Daily
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug use	<input type="checkbox"/> None	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Other	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced
Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Living status	<input type="checkbox"/> With Family	<input type="checkbox"/> With Friends	<input type="checkbox"/> Alone	<input type="checkbox"/> Other
Stroke (CVA/TIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you follow special diet?	<input type="checkbox"/> No	<input type="checkbox"/> Yes If so, What?		
Bleeding Disorders (hemophilia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use	<input type="checkbox"/> Never	<input type="checkbox"/> Quit	<input type="checkbox"/> Dip /vaping	<input type="checkbox"/> Yes ___packs/day x ___ year(s)
Adverse reaction to anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please list your hobbies:				
If deceased, at what age?						What do you do for work?				

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Review of Systems: Please check current symptoms that you have:

General	<input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Exercise intolerance
Allergy/Immunology	<input type="checkbox"/> Itching <input type="checkbox"/> Hives <input type="checkbox"/> Sneezing <input type="checkbox"/> Sinus pressure
Eyes	<input type="checkbox"/> Irritation <input type="checkbox"/> Dryness <input type="checkbox"/> Change in vision <input type="checkbox"/> Corrective Lenses
ENT	<input type="checkbox"/> Hearing loss <input type="checkbox"/> Bleeding gums/nosebleeds <input type="checkbox"/> Sinus problems <input type="checkbox"/> Dry mouth <input type="checkbox"/> Active Dental issues
Endocrine	<input type="checkbox"/> Fatigue <input type="checkbox"/> Excessive Thirst
Respiratory	<input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty breathing
Cardiovascular	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart murmur
Gastrointestinal	<input type="checkbox"/> Vomiting/nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Blood stool
Hematology	<input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendency
Genitourinary	<input type="checkbox"/> Incontinence <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Frequent urination
Musculoskeletal	<input type="checkbox"/> Joint pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Back/neck pain <input type="checkbox"/> Muscle pain/ache/cramps <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Weakness <input type="checkbox"/> Balance problems
Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Open wound or ulcer <input type="checkbox"/> Cellulitis
Neurologic	<input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Weakness <input type="checkbox"/> Light headed/dizzy
Psychiatric	<input type="checkbox"/> Depressed mode <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Anxiety

To the best of my knowledge, the questions on this form have been answered correctly. I understand that it is my responsibility to inform the doctor of any changes in my medical condition.

 Signature of Patient, or Parent Minor

 Date

 Physician Initials/Date

Patient Name:
D.O.B: Age:
Date:



1. Where is the pain located- circle? **Hip:** Left / Right **Knee:** Left / Right **Ankle:** Left / Right **Foot:** Left/Right **Shoulder:** Left/Right
2. Have you EVER worn a Brace or wrap for this joint? Yes No
3. Have you EVER tried ice or heat for this joint? Yes No
4. Have you EVER required assistance to walking (cane, walker, wheelchair)? Yes No
5. Have you EVER had physical therapy or done exercises for this joint? Yes No If so, when? _____
6. Have you EVER had surgery for this joint? Yes No
7. Have you EVER taken any medication for this joint? Yes No
- ___ Motrin/Ibuprofen/Advil/Naproxen/Aleve
 - ___ Voltaren/Diclofenac
 - ___ Tylenol
 - ___ Aspirin
 - ___ Mobic/Meloxicam
 - ___ Celebrex
 - ___ Narcotics
 - ___ Others: _____

8. Have you EVER had an injection in this joint? Yes No
- ___ Cortisone
 - ___ Rooster Comb/Cox Comb/Hyaluronic Acid (knee) If so how many? _____
 - ___ Stem Cell/Amnion How long did you have relief for? _____

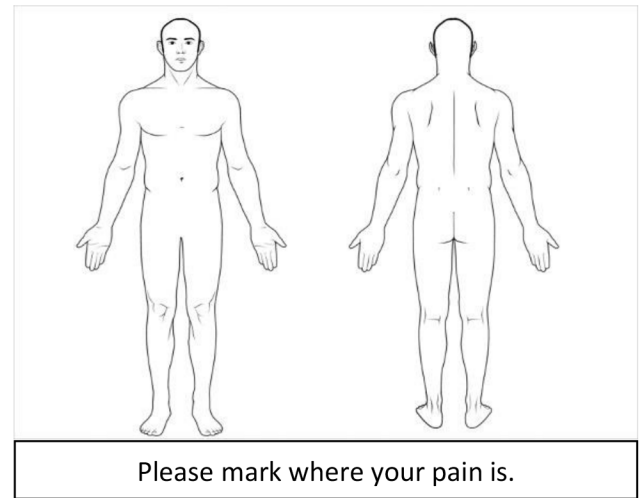
9. Please check ALL activities in which you have EVER noticed pain:
- ___ Sleeping
 - ___ Putting on socks or shoes.
 - ___ Sit and Stand.
 - ___ Walking
 - ___ In/Out of Car
 - ___ Sitting for long periods of time.

10. Does the joint feel unstable? Yes No
If so, how much (On a scale of 1-10 w/10 being very unstable)? _____

11. How long have you had this problem? _____

12. Quality of pain:
- ___ Sharp
 - ___ Throbbing
 - ___ Dull
 - ___ Tight
 - ___ Tingling
 - ___ Radiating
 - ___ Burning
13. Location of pain:
- ___ Inside (close to center of body)
 - ___ Outside (away from center of body)
 - ___ Front
 - ___ Back
14. Severity of pain: _____
(On a scale of 1-10 w/10 being most severe)

15. Timing of pain:
- ___ Rare
 - ___ Intermittent
 - ___ Constant
16. Associated signs/symptoms:
- ___ Gridding
 - ___ Popping
 - ___ Weakness
 - ___ Numbness
 - ___ Swelling
 - ___ Stiffness
 - ___ Clicking
 - ___ Night pain



17. Context (What were you doing at the onset of pain)?

18. Have you seen anyone else for this issue?

Office Use ONLY:

Height: _____ **Weight:** _____ **BMI:** _____ **BP:** _____ **HR:** _____ **Temp:** _____