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:
D.O.B: Age:
Date:

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:
D.O.B: Age:
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: _____

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

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)

Allergies to Medications: Drug Name: Type of Reaction _____ _____ _____

Drug Name: Type of Reaction _____ _____ _____

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:

BLOOD
☐ Anemia ☐ Hemophilia ☐ Sickle Cell ☐DVT
☐ Clotting problems ☐ Other: _____

INTEGUMENTARY (Skin/Nails)
☐ Cellulitis ☐ Eczema ☐ Shingles ☐ Rosacea
☐ Contact Dermatitis ☐ Psoriasis ☐ Other: _____

CANCER
☐ Breast ☐ Liver ☐ Prostate ☐ Skin ☐ Lung
☐ Leukemia ☐ Kidney ☐ Ovarian ☐ Colon ☐ Cervical
☐ Uterine ☐ Other: _____

REPRODUCTIVE
Currently Pregnant? ☐ Yes ☐ No LMP:_____
Currently Breastfeeding? ☐ Yes ☐ No

RESPIRATORY
☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD
☐ Pneumonia ☐ Clot in lungs (pulmonary embolus)
☐ Other: _____

PSYCHOLOGICAL
☐ ADD ☐ ADHD ☐ Depression ☐ Panic Disorder
☐ Bipolar Disorder ☐ PTSD ☐ Anxiety ☐ Schizophrenia
☐ Autism ☐ Other: _____

INFECTIOUS DISEASE
☐ AIDS ☐ HIV ☐ Hepatitis A/B/C ☐ Tuberculosis
☐ MRSA/VRE (resistant org) ☐ Covid 19
☐ Covid Vaccine completed ☐ Other: _____

CARDIAC
☐ Aneurysm ☐ Chest pain/angina ☐ Cardiac bypass surgery
☐ Pacemaker ☐ Heart Murmur ☐ Congestive heart failure
☐ Heart attack ☐ High blood pressure ☐ Irregular Heartbeat
☐ High Cholesterol ☐ Other:_____

EENT (Eyes/Ears/Nose/Throat)
☐ Seasonal Allergies ☐ Hearing loss ☐ Glaucoma
☐ Cataract- Left ☐ Cataract- Right
☐ Hearing device- Left ☐ Hearing device- Right
☐ Chronic Sinusitis ☐ Corrective Lenses
☐Other: _____

ENDOCRINE (Diabetes/Thyroid/Pancreas)
☐ DM Type I ☐ DM Type II ☐ Hashimoto's
☐ Hyperthyroidism ☐ **Hypo**thyroidism ☐ Addison's
☐ Cushing ☐ Graves'
☐ Other: _____

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

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

Past Surgical History: Please list ANY past surgeries.

Date	Surgery	Surgeon	Date	Surgery	Surgeon

Hospitalizations: ☐ For surgeries ☐ Others: _____ ☐ None

Family History:

☐ Adopted ☐None

	Mother	Father	Sibling	Other	Unknown
Heart/Cardiac Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Malignant Hyperthermia	☐	☐	☐	☐	☐
Stroke (CVA/TIA)	☐	☐	☐	☐	☐
Bleeding Disorders (hemophilia, etc.)	☐	☐	☐	☐	☐
Adverse reaction to anesthesia	☐	☐	☐	☐	☐
If deceased, at what age?					

Social History:

Alcohol use	☐ No	☐ Rare	☐ Moderate	☐ Daily
Do you exercise regularly?	☐ No	☐ Yes		
Drug use	☐ None	☐ Marijuana	☐ Other	
Marital Status	☐ Single	☐ Married	☐ Widowed	☐ Divorced
Living status	☐ With Family	☐ With Friends	☐ Alone	☐ Other
Do you follow special diet?	☐ No	☐ Yes If so, What?		
Tobacco use	☐ Never	☐ Quit	☐ Dip /vaping	☐ Yes ___packs/day x _____ year(s)
Please list your hobbies:				
What do you do for work?				

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

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

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

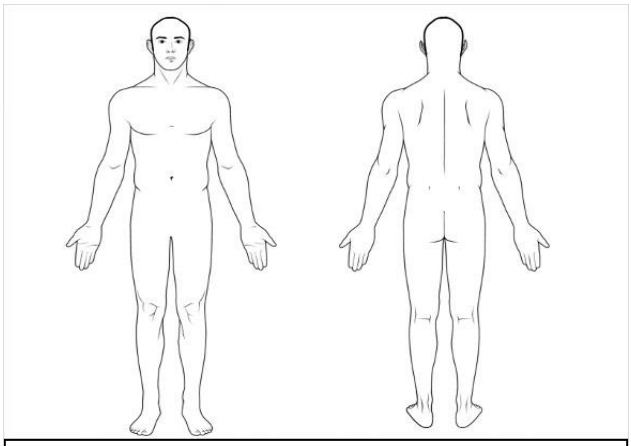
5. Have you EVER had physical therapy or done exercises for this joint? Yes No If so, when? _____

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.



Please mark where your pain is.

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:
    ___Griding ___Swelling
    ___Popping ___Stiffness
    ___Weakness ___Clicking
    ___Numbness ___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:_____