DURANGO ORTHOPEDICS

Robert Goodman, MD

Shoulder Injury Forms

Office Use Only PT Acct # ______

www.durangoorthopedics.com

Name: ______ Today's Date: ______

First M.I. Last

Mailing Address: ______

City: ______ State: ______ Zip: ______

Physical Address: ______

City: ______ State: ______ Zip: ______

Phone: ______ Birth Date: ______ Age: ______

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Cell Phone: ______

Employer: ______ Occupation: ______

Employer's Address: ______

City: ______ State: ______ Zip: ______

Work Phone: ______ Ext: ______

Referring and/or PCP: ______

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: ______ Relationship to Patient: ______

Home Address: ______

City: ______ State: ______ Zip: ______

Phone: ______ Birth Date: ______ Age: ______

Social Security Number: ______

Employer: ______ Occupation: ______

Employer's Address: ______

City: ______ State: ______ Zip: ______

Work Phone: ______ Ext: ______

In case of emergency contact: ______ Relationship: ______

Home phone: ______ Work phone: ______

Name of Primary Insurance: ______

Name of Secondary Insurance: ______

Is this a Work Comp or Motor Vehicle Accident? ☐ Yes ☐ No

If YES, on what date did the injury occur? ______

Did you report the injury to your Employer or Motor Vehicle Insurance? ☐ Yes ☐ No

Work Comp / MVA Claim Number: ______

Adjuster's Name: ______

Phone: ______ Fax: ______

We will need a copy of your insurance card(s) and driver's license.

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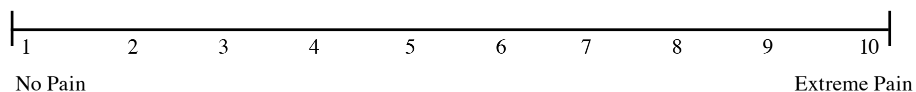
First M.I. Last

Which shoulder hurts? ☐ Right ☐ Left ☐ Both
Hand dominance ☐ Right ☐ Left ☐ Ambidex
Date of injury or onset of symptoms? ______________ Worker's comp injury? ☐ Yes ☐ No
Was the onset acute or gradual? ______________ Motor vehicle accident? ☐ Yes ☐ No
Do you have neck pain? ☐ Yes ☐ No ______________
Have you had a prior injury? ☐ Yes ☐ No Have you seen anybody else? ☐ Yes ☐ No Who: ______________

Describe your injury: ____

My main problem is: ☐ Pain ☐ Weakness ☐ Stiffness ☐ Locking ☐ Instability
(Instability means feelings of bones coming out of joint or shifting on each other.)
My shoulder catches (doesn't move freely for several seconds) ☐ Yes ☐ No
At the time of injury:
did you feel/hear a pop? ☐ Yes ☐ No
did you have swelling? ☐ No ☐ Immediately ☐ Within a few hours ☐ Overnight
Describe your pain: ____

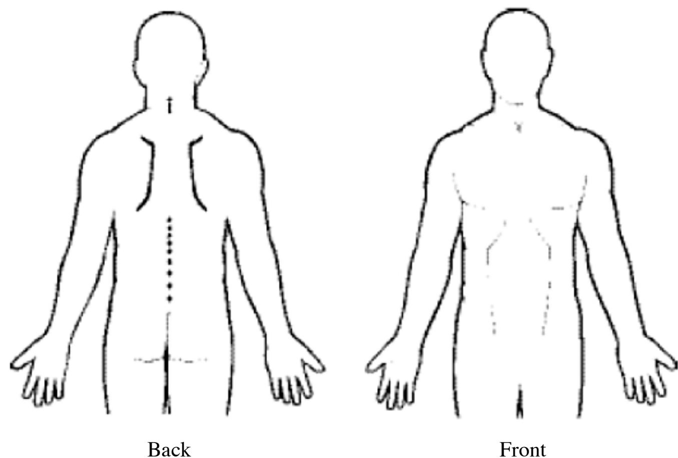
Circle your pain level on a scale of 1 to 10, with 10 being unbearable, or worst imaginable, pain.



No Pain Extreme Pain

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

Stabbing pain /////
Burning pain oooo
Aching pain xxxx
Numbness ====



Reviewed by: ______________________, MD
Date: __________

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Health History Form

Name: ______________________ DOB: ____________ Today's Date: ____________

List all past medical problems:

List all current medical problems:

Are you currently pregnant or do you think you are pregnant? ☐ Yes ☐ No

List all current medications:(including over-the-counterand herbal/supplements) ______________________

What medications have you tried in the past: ______________________

List all DRUG ALLERGIES including adverse reactions: ______________________

Review of Systems

Are you currently having or have you had problems with your:

	Check		Describe all yes responses
Eyes	☐ Yes	☐ No	
Ears, Nose, Throat	☐ Yes	☐ No	
Lungs, Breathing	☐ Yes	☐ No	
Digestion/Ulcers	☐ Yes	☐ No	
Bowel movement	☐ Yes	☐ No	
Bladder problems	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Heart problems/Chest Pain (including rheumatic fever)	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
High cholesterol	☐ Yes	☐ No	
Bleeding problems/Blood clots	☐ Yes	☐ No	
Balance problems	☐ Yes	☐ No	
Numbness/tingling	☐ Yes	☐ No	
Blackout/fainting	☐ Yes	☐ No	
Psychological problems/Depression	☐ Yes	☐ No	
AIDS/Hepatitis	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Arthritis/rheumatoid	☐ Yes	☐ No	
Weight loss/weight gain	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
Migraines or headaches	☐ Yes	☐ No	
Skin, e.g., rashes, lesions, moles	☐ Yes	☐ No	

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Past Surgical History

Have you ever had any problems with anesthesia? ☐ Yes ☐ No Explain: ______________________

Surgery	Year	Complications

Family History

Do any of your grandparents, parents, siblings, or children have any of the following diseases? Please explain.

Diabetes	☐ Yes	☐ No	______________________
High blood pressure	☐ Yes	☐ No	______________________
Heart attack	☐ Yes	☐ No	______________________
Cancer	☐ Yes	☐ No	______________________
Arthritis	☐ Yes	☐ No	______________________
Rheumatoid arthritis	☐ Yes	☐ No	______________________
Back or neck problems	☐ Yes	☐ No	______________________
AIDS/HIV	☐ Yes	☐ No	______________________
Bleeding disorders	☐ Yes	☐ No	______________________
Epilepsy	☐ Yes	☐ No	______________________
Hepatitis	☐ Yes	☐ No	______________________
Migraines/headaches	☐ Yes	☐ No	______________________
Psychiatric problems	☐ Yes	☐ No	______________________
Stomach	☐ Yes	☐ No	______________________
Thyroid problems	☐ Yes	☐ No	______________________

Social History

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you live alone? ☐ Yes ☐ No

☐ Employed (occupation ______________________) ☐ Student ☐ Retired

Children? ☐ Yes ☐ No Number: ______________________

Exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily

What type of exercise? ______________________

Smoking? ☐ Yes ☐ No __________ Packs per day for __________ years.

Quit smoking? ☐ Yes ☐ No When? ______________________

Previously smoked? ☐ Yes ☐ No __________ Packs per day for __________ years.

Chew tobacco? ☐ Yes ☐ No How much? ______________________

Drink alcohol? ☐ Yes ☐ No How much and how often? ______________________

Substance abuse? ☐ Yes ☐ No What? ______________________

Patient Signature ______________________ Date __________

Reviewed by ______________________ Date __________

MD Signature ______________________ Date __________

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What makes your pain better?______________________

____

____

____

What makes your pain worse?______________________

____

____

____

Do you have trouble with your activities of daily living? (putting on shoes/socks, cooking, laundry, bathing, etc) ☐ No ☐ Yes Explain: ______________________

____

Do you have difficulties at work? ☐ No ☐ Yes Explain: ______________________

____

____

____

Are overhead activities worse? ☐ No ☐ Yes
Have you noticed weakness? ☐ No ☐ Yes
Do you have any numbness or tingling? ☐ No ☐ Yes

What are the hobbies/sports that you participate in? ______________________

Does your pain limit your participation in these? ☐ No ☐ Yes How? ______________________

Do you have pain at rest? ☐ No ☐ Yes
Do you have pain at night? ☐ No ☐ Yes
Have you taken any medication for the pain? ☐ No ☐ Yes List,______________________

____

____

Have you tried anything else for the pain? ☐ No ☐ Ice ☐ Brace ☐ Therapy ☐ Other ______________________

Have you had steroid injections in your shoulder? ☐ Yes ☐ No Number ______________________

Patient Signature ______________________ **Date** ______________________

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Durango Orthopedics Associates, P.C.

Patient Registration and Consent for Medical Treatment

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Durango Orthopedic Associates, P.C.

2. **Authorization for Release or Information:** Durango Orthopedic Associates, P.C. and my physician may release information from my medical records to any health care provider involved in my care and treatment, including Mercy Medical Center. Durango Orthopedic Associates, P.C. and my physician may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare/Medicaid programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Durango Orthopedic Associates, P.C. is no longer responsible for the confidentiality of any information known or possessed by the payer.

3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Durango Orthopedic Associates, P.C. and of my physician, which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from Durango Orthopedic Associates, P.C., I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Durango Orthopedic Associates, P.C.

4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Durango Orthopedic Associates, P.C. charges.

5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Durango Orthopedic Associates, P.C. and my physician for charges not paid.

I acknowledge that:

I have read this form and understand its contents

I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms

I am responsible for the payment and/or co-payment that is due at the time of service

______________________________ ______________________________

Signature of Patient or Legally Responsible Person | Name (Print)

______________________________ ______________________________

Relationship/Reason Why Patient is Unable to Sign | Date