



1702 W. Fairview Ave Boise, Idaho 83702 Phone: (208) 957-7400 Fax: (877) 287-3117 frontdesk@gustavelorthopedics.com

PATIENT DEMOGRAPHICS

Legal First Name Legal Last Name Middle Initial Maiden Name

/ /
Date of Birth Age

Billing Address Apt. # City State Zip

Primary Phone number Additional Phone Number

How would you like to receive appointment reminders? (Circle one): Call Text Email

Social Security Number Email Address

Preferred Pharmacy Pharmacy Street or Address

Marital Status (Circle one): Single Married Divorced Widowed Decline Sex (circle one): Male Female Transgender

Is your condition a work injury? Yes ___ No ___ Auto accident? Yes ___ No ___

Preferred Language: _____ Ethnicity: Hispanic or Latino ___ Non-Hispanic or Latino ___
Race: American Indian or Alaskan Native ___ Asian ___ Black/African American ___ White ___
Native Hawaiian or Pacific Islander ___

EMERGENCY CONTACT INFORMATION

Contact Name Contact Phone Number Relationship to Patient

REFERRAL INFORMATION

Referring Physician Referring Physician Phone Number

How did you hear about us? (Circle one): Family/Friend Physician Physical Therapist Internet Other

Patient name: _____

INSURANCE INFORMATION

Primary Insurance Information	Policy/Claim#	Group #	Effective date
Policy Holder's Name	Policy Holder Date of Birth	Relationship to Patient	
Secondary Insurance Information	Policy/Claim#	Group #	Effective Date
Secondary Insurance Policy Holder's Name	/ / Date of Birth	Relationship to Patient	

WORKERS COMPENSATION INSURANCE

Insurance Company Name/Address	Claim Number	Phone/Name of Representatives
--------------------------------	--------------	-------------------------------

My signature shows that I attest to all of the information provided on these sheets are correct and filled out to the best of my knowledge and ability.

Signature of Patient: _____
(Patients must be 18 years or older to sign. Parent or guardian signature required if under 18 years or age)

Date: _____

Please **DOWNLOAD** and complete forms. Fax to (877) 287 - 3117. Email to frontdesk@gustavelorthopedics.com, or print in advance of your appointment. Forms will be signed at your appointment.

PATIENT INTAKE HISTORY

Body part to be Examined: _____ (Circle one): Right Left Bilateral

Approximate Date of Symptom Onset or Injury.

Mechanism of Injury (if applicable).

What treatment have you tried? (Circle all that apply):

Rest Ice Heat Oral Medications Topical Medications NSAIDS Steroid Injections
Physical Therapy Home Exercises Wearing a Sling, Brace or Orthotics TENS Unit Chiropractic Care

How many weeks of Physical Therapy? _____ Start Date _____ End Date _____

How many weeks of Home Exercises as directed by a Physician or Physical Therapist? _____

CURRENT MEDICATIONS (Please include any over-the-counter medications, vitamins, etc.)

Name	Strength	How Often

ALLERGIES

(Circle all that apply) Latex Sutures Tape/Adhesives Metal, Type of Metal: _____

No Known Drug Allergies (NKDA)

PAST MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO
Asthma			Fibromyalgia			Sleep Apnea		
Atrial Fibrillation			Gallbladder problems, Stones, or disease			Seizure Disorder		
Bleeding Tendencies			Hepatitis A			Osteoporosis		
DVT or Blood Clots			Hepatitis B			Osteoarthritis		
Concussion			Hepatitis C			MRSA		
COPD			High Blood Pressure			Liver Problems or Jaundice		
Emphysema			HIV or AIDS			Kidney Disease		
Diabetes Type 1			Problems with Anesthesia					
Diabetes Type 2			Thyroid Disease					
Endocrine Disorder			Stomach Ulcer			Other, please list:		

PAST SURGICAL HISTORY

Procedure Type

Surgeon

Date

FAMILY MEDICAL HISTORY

	HEART DISEASE	DIABETES	HYPERTENSION	CANCER	OTHER
FATHER					
MOTHER					

SOCIAL HISTORY

List Recreational Activities or Hobbies:

Tobacco Use? No _____ Yes _____ Pack per day: _____ For how long? _____ Quit Date: _____
Type (Circle all that apply): Chew Cigars Cigarettes Vape

Alcohol Use? No _____ Yes _____ Drinks per week: _____ Quit Date: _____

Recreational Drug Use? No _____ Yes _____ Frequency: _____ For how long? _____

Dominant Hand (Circle one): Right Left

Occupation: _____ Patient is a Student (Circle one): Full-Time Part-Time

PATIENT HEALTH HISTORY

Are you currently Pregnant? No _____ Yes _____ Are you currently Breastfeeding? No _____ Yes _____

Are you currently on a pain contract? No _____ Yes _____

Height _____ Weight _____

Rate your pain on a scale of 1-10, with 10 being the worst. _____