VIRGIN ISLANDS ORTHOPAEDICS & MEDICAL SPECIALISTS ACTIVE PHYSICAL THERAPY

New Patient Registration Form

Rheumatology - Dr. Mary Olsen, MD

Today's Date:_____ Account #_____

Name: _____ DOB: _____ Preferred Language: _____

Mailing Address:_____ Age: _____ E-Mail: _____

City, State, Zip: _____ SSN: _____ Preferred Pharmacy: _____

Home Phone: _____ Cell Phone: _____ Marital Status: Married ( ) Single ( ) Widowed ( ) Divorced ( )

In case of Emergency, Notify: _____ Sex: Male ( ) Female ( )

Phone: _____ Referred by: _____

Relationship to patient: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

ID Number: _____ Group Number: _____ ID Number: _____ Group Number: _____

Mailing Address: _____ Mailing Address: _____

City, State, Zip: _____ City, State, Zip: _____

Name/Policy Holder: _____ Name/Policy Holder: _____

SSN: _____ SSN: _____

DOB: _____ Relationship to Patient: _____ DOB: _____ Relationship to Patient: _____

Employment Information

Employer: _____ Telephone: _____

Mailing Address: _____ City, State, Zip: _____

Responsible Party Information

Name: _____

Mailing Address: _____

City, State, Zip: _____

DOB: _____ E-Mail: _____

SSN: _____

As the responsible party, I agree that all charges that are not directly paid by the insurance company will be my responsibility

X _____
Responsible Party Signature

Phone: _____

Payment of Benefits

I authorize payment of benefits, as determined by the insurance company, directly to the physician's office. I understand that I still may be responsible for any amounts not paid by my insurance company.

Signature: _____ Date: _____

Medical Release Authorization

I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that all information on this form is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature: _____ Date: _____

Cancellation of Scheduled Appointments

I understand that if I have a serious emergency and I am unable to come to my appointment, I will contact the office as soon as possible. In other cases, if I fail to cancel my appointment 24 business hours in advance, I will be charged $50.00 for the missed appointment.

Signature: _____ Date: _____

AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: _____/_____/_____ Time of appointment: _____ Birthplace: _____
MONTH DAY YEAR

Name: _____ Birthdate: _____/_____/_____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Referred here by: *(check one)* ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

Date symptoms began *(approximate)*: _____ Diagnosis: _____

Previous treatment for this problem *(include physical therapy, surgery and injections; medications to be listed later)*: _____

_____

_____

_____

_____

_____

_____

Please list the names of other practitioners you have seen for this problem:

_____

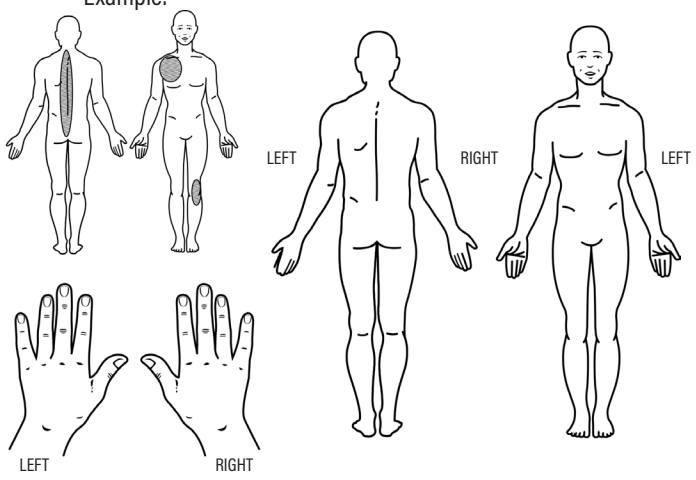
_____

_____

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? *(check if "yes")*

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions: _____

Patient's Name: _____ Date: _____ Physician Initials: _____

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: _____/_____/_____ Date of last eye exam: _____/_____/_____ Date of last chest x-ray: _____/_____/_____

Date of last Tuberculosis Test _____/_____/_____ Date of last bone densitometry _____/_____/_____

Constitutional

- ❑ Recent weight gain amount _____
- ❑ Recent weight loss amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing

Cardiovascular

- ❑ Chest Pain
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, “smoky” urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? _____/_____/_____

Date of last pap? _____/_____/_____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness

  Lasting how long?

  _____Minutes _____Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

  List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient’s Name: _____ Date: _____ Physician Initials: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No

If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

PAST MEDICAL HISTORY

Do you now have or have you ever had: *(check if "yes)*

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever
❑ Bad headaches	❑ Jaundice	❑ Colitis
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness *(please list)* _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes *Describe:* _____

Any other serious injuries? ❑ No ❑ Yes *Describe:* _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number decreased _____

Number of siblings _____ Number living _____ Number decreased _____ List ages of each _____

Health of children _____

_____

Do you know any blood relative who has or had: *(check and give relationship)*

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever _____	❑ Tuberculosis _____
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy _____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism _____	❑ Psoriasis _____	

Patient's Name: _____ Date: _____ Physician Initials: _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes If yes, please list: _____

_____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: *Helped?*		
			A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS: Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac					
Pain Relievers					
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Propoxyphene		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		❑	❑	❑	
Golimumab		❑	❑	❑	
Hydroxychloroquine		❑	❑	❑	
Penicillamine		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine		❑	❑	❑	
Sulfasalazine		❑	❑	❑	
Quinacrine		❑	❑	❑	
Cyclophosphamide		❑	❑	❑	
Cyclosporine A		❑	❑	❑	
Etanercept		❑	❑	❑	
Infliximab		❑	❑	❑	
Tocilizumab		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name: _____ Date: _____ Physician Initials: _____

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		❑	❑	❑	
Alendronate		❑	❑	❑	
Etidronate		❑	❑	❑	
Raloxifene		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal		❑	❑	❑	
Risedronate		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen		❑	❑	❑	
Tiludronate		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyaluronan		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	

Please list supplements:

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list:

Patient's Name: _____ Date: _____ Physician Initials: _____

ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No *If yes, how many?*

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness	❑	❑	❑
Do you use a cane, crutches, walker or wheelchair? *(circle one)*	❑	❑	❑

What is the hardest thing for you to do? _____

Are you receiving disability? Yes ❑ No ❑

Are you applying for disability? Yes ❑ No ❑

Do you have a medically related lawsuit pending? Yes ❑ No ❑

Patient's Name: _____ Date: _____ Physician Initials: _____

How does your condition affect everyday activities?

Fill out this simple form to assess how your condition may be impacting your daily life, and share the answers with your doctor. He or she may find the information useful when evaluating your condition and discussing treatment options.

» Health Assessment Questionnaire–Disability Index*

Patient's Name: _____ Date: _____

Please check the response that best describes your usual abilities over the past week:	WITHOUT ANY DIFFICULTY (0)	WITH SOME DIFFICULTY (1)	WITH MUCH DIFFICULTY (2)	UNABLE TO DO (3)
» Dressing & Grooming – *Are you able to:*				
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
» Arising – *Are you able to:*				
Stand up from a straight chair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
» Eating – *Are you able to:*				
Cut your meat?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Open a new milk carton?	☐	☐	☐	☐
» Walking – *Are you able to:*				
Walk outdoors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐

THIS COLUMN IS FOR PHYSICIAN USE ONLY

For each category (ie, "Dressing & Grooming"), enter the highest number checked in each row (0, 1, 2, or 3).

Note to physician: The following aids and categories correlate to the activities listed above. If an item below is selected, and its corresponding activity (listed above) has been scored a 1, it will change to a 2.

Please check any AIDS OR DEVICES that you usually use for any of these activities:

- ☐ Cane
- ☐ Walker
- ☐ Crutches
- ☐ Wheelchair
- ☐ Devices used for dressing (button hook, zipper, long-handled shoehorn, etc)
- ☐ Built-up or special utensils
- ☐ Special or built-up chair
- ☐ Other (Specify:_____)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

- ☐ Dressing & Grooming
- ☐ Arising
- ☐ Eating
- ☐ Walking

» Hygiene – *Are you able to:*					
Wash and dry your body?	☐	☐	☐	☐	
Take a tub bath?	☐	☐	☐	☐	
Get on and off the toilet?	☐	☐	☐	☐	
» Reach – *Are you able to:*					
Reach and get down a 5-pound object (such as a bag of sugar) from above your head?	☐	☐	☐	☐	
Bend down to pick up clothing from the floor?	☐	☐	☐	☐	

Flip the sheet to complete this form.

Please check the response that best describes your usual abilities over the past week:	WITHOUT ANY DIFFICULTY (0)	WITH SOME DIFFICULTY (1)	WITH MUCH DIFFICULTY (2)	UNABLE TO DO (3)
» **Grip** – *Are you able to:*				
Open car doors?	☐	☐	☐	☐
Open previously opened jars?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
» **Activities** – *Are you able to:*				
Run errands and shop?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Do chores such as vacuuming or yard work?	☐	☐	☐	☐

THIS COLUMN IS FOR PHYSICIAN USE ONLY

For each category (ie, "Dressing & Grooming"), enter the highest number checked in each row (0, 1, 2, or 3).

☐

☐

Note to physician: The following aids and categories correlate to the activities listed above (Hygiene through Activities). If an item below is selected, and its corresponding activity (listed above) has been scored a 1, it will change to a 2.

Please check any AIDS OR DEVICES that you usually use for any of these activities:

- ☐ Raised toilet seat
- ☐ Bathtub seat
- ☐ Jar opener (for jars previously opened)
- ☐ Bathtub bar
- ☐ Long-handled appliances for reach
- ☐ Long-handled appliances in bathroom
- ☐ Other (Specify:_____)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

- ☐ Hygiene
- ☐ Reach
- ☐ Gripping and opening things
- ☐ Errands and chores

We are also interested in learning whether or not you are affected by pain because of your illness.

How much pain have you had because of your condition in the *PAST WEEK*?

Place a single vertical mark (|) on the line to indicate the severity of the pain.

No Pain — Severe Pain

0 — 100

Pain Score ☐

Considering all the ways that your arthritis affects you, rate how you are doing on the following scale by placing a vertical mark on the line

Very Well — Very Poor

0 — 100

Pain Score ☐

*The Health Assessment Questionnaire (HAQ) Disability Index was developed by James F. Fries, MD, and colleagues at Stanford University and measures disability with the use of aids and devices. It is scored on a scale of 0 to 3 units. A score of 0 indicates the lack of any measurable degree of disability, whereas a score of 3 means that a patient is unable to perform all activities.

☐ ***TOTAL (Page 1 and 2)***

☐ ***÷ Number of answered groups***

☐ ***TOTAL HAQ Disability Index Score***

Please list any other activities you were previously able to do, but now can't because of your condition.

Ask your doctor if additional treatment options may be appropriate for your condition.

»

Have additional questions for your doctor? Jot them down and start a conversation.

»

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Cardiology | Orthopaedics | Pain Management | Rheumatology
Rehabilitation | Wellness | Wound Care

Cancellation Policy/No Show Policy

For Doctor Appointments and Surgery

1. **Cancellation/ No Show Policy for Appointment**
   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a ***fifty-dollar ($50) fee***; this will not be covered by your insurance company.
2. **Scheduled Appointments**
   We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we may have to reschedule the appointment.
3. **Cancellation/ No Show Policy for Surgery**
   Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 10 days in advance you will be charged a ***two hundred dollar ($200) fee***; this is will not be covered by your insurance company.
4. **Account balances**
   We will require that patients with self-pay balances do pay their account balances to ***zero (0)*** prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ ____/____/____

Print Name Patient **Signature Patient/Guardian** **Date**

Patient Account #_____

(Office Use Only)