ASHEVILLE NON SURGICAL ORTHOPEDICS
675 BILTMORE AVENUE, SUITE F
ASHEVILLE, NC. 28803
(828) 417-9913

PATIENT INTAKE FORM

Today's Date: ____/____/____

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ Date of Birth: ____/____/____

Home Address: _____
Street *City* *State* *Zip*

Home Phone: _____ Cell Phone: _____ Work Phone: _____ EXT: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Marital Status (Circle One): M S W D

How did you hear about Asheville Non Surgical Orthopedics?

_____

Primary Care Physician: _____

Clinic or Practice Name: _____

Address: _____ Phone: _____

Social History:

Employer: _____ Occupation: _____

Do you use any of the following (Check all that may apply):

	YES	NEVER	QUIT	AMOUNT PER DAY
Tobacco	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Recreational Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

Chief Complaint Information

Name: _____ DOB: _____

Reason for today's visit/primary complaint: _____

How long has this condition been present: _____

Have you had similar issues in the past: _____

Is this condition getting better or worse: _____

How would you describe the pain: _____

What makes it better: _____

What makes it worse: _____

Is it constant or intermittent: _____

Severity scale at best and at worst (0-10 with 10 being the worst): _____

Has this complaint been evaluated, by whom and what is this provider's specialty: _____

What treatment has been suggested and/or attempted and what was the result: _____

Have you had any imaging: _____

Please describe any other symptoms and additional comments: _____

_____

Any supplements, dosages and frequency: _____

_____

Additional symptoms (check all that apply)

- ☐ Numbness
- ☐ Tingling
- ☐ Burning
- ☐ Radiating Pain
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Spasm
- ☐ Muscle Weakness
- ☐ Redness

Any known allergies: _____

MR# _____

Patient Medical History:

Condition	Date	Treatment/Outcome

Previous Surgical History:

Procedure	Hospital	Date

Family Medical History:

Family Member	Illness	Deceased	Living

Last Name: _____ First Name: _____

Primary Insurance Plan

Insurance Carrier: _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

*** If you are *not* the Policy Holder for the Primary Insurance, please complete:**

Insurance Policy Holder: Spouse _____ Parent _____ Other _____

Policy Holder Name: _____ Date of Birth: ____/____/____

Secondary Insurance Plan (if any)

Insurance Carrier: _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

*** If you are *not* the Policy Holder for the Secondary Insurance, please complete:**

Insurance Policy Holder: Spouse _____ Parent _____ Other _____

Policy Holder Name: _____ Date of Birth: ____/____/____

Last Name: _____ First Name: _____