

# Intake form



Main Line HealthCare  
Physician Network

Please check or fill in completely.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Pain:  Neck  Back  Arms  Legs

Pain in which side?  Left  Right  Both

If all your pain equals 100%, assign each area a percentage:  
Arm: \_\_\_\_\_ Leg: \_\_\_\_\_ Back: \_\_\_\_\_ Neck: \_\_\_\_\_

Worse when:  Standing  Sitting  Walking  All

How far can you walk? \_\_\_\_\_

Better when:  Standing  Sitting  Walking  
 Lying down  No different

What position give least amount of pain? \_\_\_\_\_

Pain aggravated by:  Coughing  Sneezing  Straining  
 Bending (Forward/Backward *circle one*)

How long have you had the present pain? \_\_\_\_\_

What do you think started your pain? \_\_\_\_\_

## IMAGING

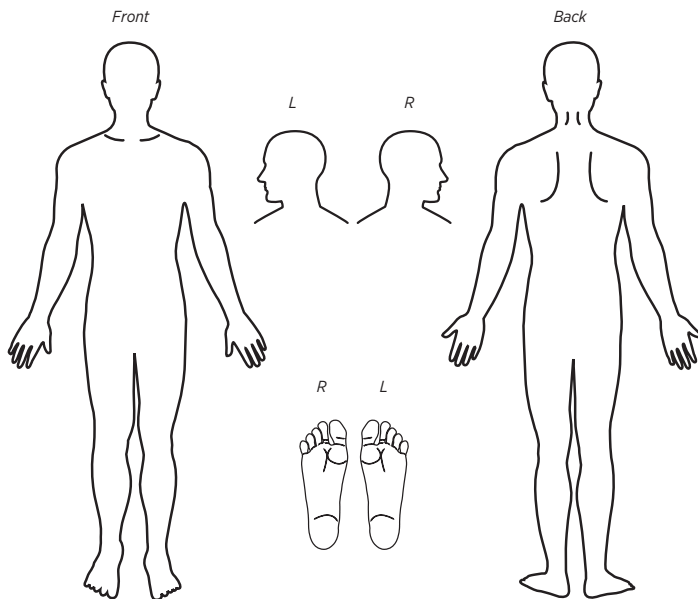
Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you had any of the following?

Body part	Date
Myelogram	_____
Discogram	_____
Plain x-rays	_____
MRI/MRA	_____
CT/CTA scan	_____
EMG	_____
DSA	_____

Is this a second opinion?  Yes  No

On diagram, please SHADE IN the location of your pain.  
Please CIRCLE the one most painful area.



Check all that describes pain:

- Sharp
- Shooting
- Throbbing
- Stabbing
- Burning
- Aching
- Sickening
- Punishing

Place an "X" on the line below to indicate the level of your pain in the following:

Average level of pain you have every day...  
No pain |-----| Worst possible pain

Level of pain you have now...  
No pain |-----| Worst possible pain

### Previous treatments:

- |                     |                                    |  |
|---------------------|------------------------------------|--|
| Acupuncture         | <input type="checkbox"/> Effective | <input type="checkbox"/> Not effective |
| Chiropractor        | <input type="checkbox"/> Effective | <input type="checkbox"/> Not effective |
| Biofeedback         | <input type="checkbox"/> Effective | <input type="checkbox"/> Not effective |
| Anti-inflammatories | <input type="checkbox"/> Effective | <input type="checkbox"/> Not effective |
| Injections          | <input type="checkbox"/> Effective | <input type="checkbox"/> Not effective |
| Anti-depressants    | <input type="checkbox"/> Effective | <input type="checkbox"/> Not effective |
| Sedatives/Narcotics | <input type="checkbox"/> Effective | <input type="checkbox"/> Not effective |
| Physical therapy    | <input type="checkbox"/> Effective | <input type="checkbox"/> Not effective |

# MAIN LINE HEALTH ORTHOPAEDICS AND SPINE

Please check or fill in completely.

Date of birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  Male  Female

List all surgeries (with date and surgeon's name):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Social history:

Do you drink alcohol?  No  Yes (Number per day \_\_\_\_\_)

Do you smoke cigarettes?  No  Yes (Number per day \_\_\_\_\_)

Current or recent occupation: \_\_\_\_\_

Disabled?  No  Yes

Any litigation in process?  No  Yes

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Scott A. Rushton, MD

\_\_\_\_\_  
Date

### Do you have significant problems with these other areas?

- |                               |                             |                              |
|-------------------------------|-----------------------------|------------------------------|
| Weight loss.....              | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Loss of appetite.....         | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Fever/chills.....             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Double/blurred vision.....    | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Ring in ears.....             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bloody nose/gums.....         | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Sore throat.....              | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Chest pain.....               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Palpitations.....             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Shortness of breath.....      | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cough.....                    | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Speech.....                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Leg/arm weakness.....         | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blood in stool.....           | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Constipation/diarrhea.....    | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blood in urine.....           | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Abdominal pain.....           | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Change in bladder habits..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Rashes.....                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bruises.....                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Headache.....                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Dizziness.....                | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blackouts.....                | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Numbness/tingling.....        | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Seizures.....                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Pain in other joints?.....    | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If yes, please list: \_\_\_\_\_

### Past medical history includes:

- |                           |                             |                              |
|---------------------------|-----------------------------|------------------------------|
| High blood pressure.....  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Peptic ulcer.....         | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Frequent infections.....  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bleeding problems.....    | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Stroke.....               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Anesthesia problems.....  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Liver disease.....        | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Rheumatoid arthritis..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cardiac disease.....      | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Angina.....               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Thyroid.....              | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Diabetes.....             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Sleep apnea/c-pap.....    | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blood clot.....           | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cancer.....               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Emphysema.....            | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Depression/anxiety.....   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Asthma.....               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Other medical conditions: \_\_\_\_\_

### Family history of:

- |                           |                             |                              |
|---------------------------|-----------------------------|------------------------------|
| Rheumatoid arthritis..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Diabetes.....             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cancer.....               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart disease.....        | <input type="checkbox"/> No | <input type="checkbox"/> Yes |



# Registration form



Main Line HealthCare  
Physician Network

## PATIENT INFORMATION

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of birth: \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  Male  Female

Home #: \_\_\_\_\_

Allergies: \_\_\_\_\_

Work #: \_\_\_\_\_

Email: \_\_\_\_\_

Cell #: \_\_\_\_\_

Marital status:  
 Single  Married  Widowed  Divorced  Separated

Employer: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Employer address: \_\_\_\_\_  
\_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Who referred you? \_\_\_\_\_

Primary/family doctor: \_\_\_\_\_

Referring phone #: \_\_\_\_\_

Physician: \_\_\_\_\_

Referring address: \_\_\_\_\_

Address: \_\_\_\_\_

Race:  African American  American Indian  Asian  Caucasian  Native Hawaiian/Pacific Islander  Unknown/declined

Language spoken:  English  Other (please specify): \_\_\_\_\_

Ethnicity:  Hispanic  Non-hispanic or Latino  Latino  Unknown/declined

## INSURANCE INFORMATION

Primary insurance: \_\_\_\_\_

Secondary insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Phone #: \_\_\_\_\_

ID #: \_\_\_\_\_

ID #: \_\_\_\_\_

Group: \_\_\_\_\_ Effective date: \_\_\_\_\_

Group: \_\_\_\_\_ Effective date: \_\_\_\_\_

Policyholder: \_\_\_\_\_

Policyholder: \_\_\_\_\_

Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

### If your visit is related to an auto accident or worker's compensation claim, please complete the following:

Insurance: \_\_\_\_\_

Accident date: \_\_\_\_\_

Address: \_\_\_\_\_

State where accident occurred: \_\_\_\_\_

Claim #: \_\_\_\_\_

Adjuster phone #: \_\_\_\_\_

**PLEASE RETURN Registration, Intake and Medication forms in the attached envelope at your earliest convenience.**