Restore Osteo
OF COLORADO

PERSONAL HEALTH HISTORY

Name:_____**Date of Birth**_____**Age:**_____

Home phone:_____**Cell phone:**_____**Date:**_____

Home Address:_____

Email:_____

May we leave messages?Y/N Text Messages?Y/N

How did you hear about us?_____

Emergency contact:_____ **Relationship:**_____

Phone #:_____

What information do you allow us to release to this person in the event of an emergency in regards to your care?_____

Current Medical Problems:

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Please list all prescribed & over the counter medications; including supplements taken regularly

Medication/dose	For treatment of	Medication/Dose	For treatment of
1.		6.	
2.		7.	
3.		8.	
4.		9.	

Allergies:_____

If so please list and include reaction type:

_____.

Product	Current use?	Quantity/ day	Quantity/ week	Past use?	Do others have concerns about your usage?
Tobacco					
Alcohol					
Recreational Drugs					
Caffeine					

Patient Name: _____ ***Today's Date:***_____

Restore Osteo
OF COLORADO

Preventive Health Please provide the dates:

	Date:		Date:
PAP/Pelvic exam(women)		Tetanus vaccine (TD or TDAP)	
Mammogram (women)		Flu Vaccine	
Colonoscopy		Pneumonia vaccine	
Test of stool for blood		Shingles Vaccine	
Rectal Prostate exam (Men)		Hepatitis A	
Prostate Specific Antigens (Men)		Hepatitis C	
Bone Density (DEXA)		MMR	
Eye Exam		Gardasil (HPV)	
Cardiovascular Stress Test		Other:	

What are your health goals for improving your overall health?

_____

_____

Is there anything else that would be helpful for us to know about you:

_____

_____

Patient Signature: _____ Date: _____

CONSENT TO X-RAY

Adult Male:

This consent form is a consent for X-Rays: I hereby authorize the performance of diagnostic X-Rays. The doctor has requested the X-Ray for further diagnostic purposes. At this time, I know of no other condition which the taking of X-Rays would further complicate.

Signature: _____ **Date:_____**

Adult Female:

Regarding the possibility of pregnancy this is to certify that; to the best of my knowledge, I am **NOT** pregnant. The doctor has permission to perform diagnostic X-Rays. I am aware that taking X-Rays, particularly those involving the pelvis can be hazardous to an unborn child.

Signature: _____ **Date:_____**

Patient Name: _____ ***Today's Date:***_____

Restore Osteo
OF COLORADO

1. Have you experienced any knee pain recently? **Yes or No**
2. If so, are you having pain in the left knee? **Yes or No** Right knee? **Yes or No**
3. Do you experience pain in both knees at times? **Yes or No**
4. Have you had any x-rays or MRI done on your knees? **Yes or No** If so, where and when
   _____
5. Is your knee pain a result of an accident or injury that you incurred? **Yes or No**
6. Have you ever had any knee surgeries? **Yes or No**. If yes, when was your last surgery?
   _____
   _____
7. Have you ever been diagnosed w/arthritis of the knees? **Yes or No** Any type of osteoarthritis? **Yes or No**
8. Have you ever had any knee injections? **Yes or No;** If yes, when was your last injection & by whom: _____
9. Does your current knee pain affect your quality of life? **Yes or No** *For example*: does it prevent you from attending certain events or engaging in any physical activity? **Yes or No** Please explain:_____
10. Any recent falls? **Yes or No** When?_____
11. How many falls have you experienced within the last 6 months? _____
12. Are you experiencing any numbness, tingling, or burning sensation with the knee pain? **Yes or No**_____
13. Do you currently use a cane or other device to help you walk? **Yes or No** If so, what do you use?
    _____
14. Have you attempted to lose weight because of the pain? **Y or N**. If you have lost weight recently, how much have you lost?_____ Has it helped improve your pain symptoms? **Y or N**_____
15. Have you ever experienced any buckling of the knees upon walking? **Y or N**
16. Does your current pain cause any depression? or suicidal thoughts? **Y or N**
17. Does your current pain interfere with your ability to sleep at night? **Y or N**
18. Have you attempted to use any kind of hot or cold therapies to help with the pain? **Y or N** If so, did any of this work? _____
19. Are you currently using opioids(pain medication) to assist with the pain? **Y or N**- If yes, how long have you been taking the medications? _____
20. If you don't use prescribed pain medication, what kind of medication do you use? Are they helping? _____
    _____
21. Do you experience any pain relief from the medications you are taking? **Y or N**

Patient Name: _____ ***Today's Date:***_____

Restore Osteo
OF COLORADO

The Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC)

Instructions: Please rate the activities in each category according to the following scale of difficulty: **0 = None 1 = Slight 2 = Moderate 3 = Very 4 = Extremely**

Circle one number **for each activity**

PAIN

Walking	0	1	2	3	4
Stair Climbing	0	1	2	3	4
At Night	0	1	2	3	4
At Rest	0	1	2	3	4
Weight Bearing	0	1	2	3	4

STIFFNESS

In the Morning	0	1	2	3	4
In the Afternoon	0	1	2	3	4
In the Evening	0	1	2	3	4

PHYSICAL FUNCTION

Going Downstairs	0	1	2	3	4
Going Upstairs	0	1	2	3	4
Sitting	0	1	2	3	4
Rising From Sitting	0	1	2	3	4
Standing	0	1	2	3	4
Bending To Floor	0	1	2	3	4
Walking on a Flat Surface	0	1	2	3	4
Getting IN/OUT of the Car	0	1	2	3	4
Going Shopping	0	1	2	3	4
Putting on Socks	0	1	2	3	4
Taking Socks Off	0	1	2	3	4
Lying in Bed	0	1	2	3	4
Rising From the Bed	0	1	2	3	4
Getting IN/OUT of the Bath	0	1	2	3	4
Getting ON/OFF the Toilet	0	1	2	3	4
Heavy Domestic Duties	0	1	2	3	4
Light Domestic Duties	0	1	2	3	4

TOTAL:_____/96=_____

Patient Name: _____ ***Today's Date:***_____

Restore Osteo
OF COLORADO

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

I,_____have received notice of our Privacy practices for the office of **Restore Osteo of Colorado LLC. DBA Restore Medical Group** *(Copies are provided upon request)*.

Please Print Name: _____

Signature:_____ Date: _____

I decline to sign the Acknowledgement because:_____

_____

_____

Patient Name: _____ ***Today's Date:***_____