# ORTHOPAEDICS & RHEUMATOLOGY OF THE NORTH SHORE

EDWARD L. SCLAMBERG, MD
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ERIN ARNOLD, MD

**ALL SECTIONS MUST BE COMPLETED**

(A new form must be completed every 12 months per insurance regulations)

## PATIENT REGISTRATION

| | | |
|---|---|---|
| Last Name: | First Name: | Date of birth: |
| Social Security #: | Marital Status: | |
| Home Phone #: | Cell Phone#: | |
| Address: | City: State: | Zip code: |
| Email address: | | |
| Race: | Ethnicity: | |
| Primary Language: | Secondary Language: | |
| Pharmacy Name: | | |
| Pharmacy Address: | Phone: - - | |
| Primary Care Physician: | | |
| PCP Address: | Phone: - - | |

## PATIENT INFORMATION

Are you retired? YES NO

| | | |
|---|---|---|
| Employer: | Work Phone #: | |
| Patients Occupation: | | |
| Address: | City: State: | Zip code: |
| Is your present condition related to an accident? YES NO | If yes date of accident: | |
| Work related: YES NO | Auto accident: YES NO | State accident occurred: |

## WORKMANS COMPENSATION INFORMATION

| | | |
|---|---|---|
| Insurance Name: | | |
| Address: | City: State: | Zip code: |
| Contact Person: | Phone #: | |
| Claim #: | | |

## SPOUSE OR PARENT/GUARDIAN REGISTRATION TO THE INSURED

(If not patient)

| | | |
|---|---|---|
| Name: | Social Security #: | |
| Address: | City: State: | Zip code: |
| Date of birth: | Retired: YES NO | Relationship to patient: |

## CONTACT PERSON IN CASE OF EMERGENCY

| | | |
|---|---|---|
| Name: | Relationship: | Phone#: |

I acknowledge receipt of notice of privacy practices (HIPAA).
I authorize release of medical information.
I authorize payment of medical benefits to the physician.
I authorize the physician to provide treatment.

Patient signature: X _____ Date: X _____

ORTHOPAEDICS AND RHEUMATOLOGY OF THE NORTH SHORE

ORTHOPAEDICS
EDWARD L. SCLAMBERG, M.D.
STEVEN G. SCLAMBERG, M.D.

4709 W. GOLF RD, SUITE 1200
SKOKIE, IL 60076

RHEUMATOLOGY
ERIN L. ARNOLD, M.D.
WILLIAM J. ARNOLD, M.D.

PHONE: 847-869-7233
FAX : 847-869-9461

# ACKNOWLEDGMEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

I, _____ have read/received a copy of this office's
(Please print name)

Notice of Privacy Practices.

X _____ ___/___/___
(Signature) (Date)

**For Office Use Only**

We attempted to obtain written acknowledgment of recipt of our Notice of Privacy Practices but acknowledgement could not be obtained because :

□ Individual refused to sign
□ Communications barriers prohibited obtaining the acknowledgement
□An emergency prevented us from obtainging acknowledgement
□Other (please specify)

_____

_____

ORTHOPAEDICS AND RHEUMATOLOGY OF THE NORTH SHORE

## Acknowledgment of Receipt of Financial Policy

Patient Name: _____ DOB: ____/____/____

Thank you for choosing us as your care provider. We are committed to the successful treatment of your medical condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our office if you have any questions.

The patient, or legal guardian, is always responsible for payment. In consideration of services to be rendered, you, as the undersigned patient or guarantor for patient, agree to pay Orthopaedics and Rheumatology of the North Shore (ORNS) for all services and supplies provided to you (of the patient, as applicable) at the established rates, including any deductibles, co-payment or other charges, as permitted by third party payors. By signing this financial policy summary, you accept responsibility for any costs, including attorney's fees incurred by ORNS in the collection of these charges for examination, diagnosis and treatment received. Furthermore, you certify that the information given by you for purposes of payment is, to the best of you knowledge, complete and accurate.

Additionally:

- Full payment is due at the time of service for self-pay patients or if insurance information (and copy of insurance card) has NOT been provided.
- All patients must complete our "patient registration form" and other forms provided at the time of registration.
- If you would like us to bill your insurance directly, we MUST HAVE A COPY OF THE CURRENT INSURANCE ID CARD otherwise you will be billed.
- Please notify us immediately of any changes in your insurance information or coverage.
- At least 24 hours' notice is required for copies of medical records or x-rays and these may be a nominal fee.
- If you're here for a workers' compensation or accident claim, we will need your health insurance information and will bill that insurance if we do not receive proper documentation and/or payment form the workers' compensation or accident insurance carrier.
- You are ultimately responsible for payment of all services.

***Medicare:*** We accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between Medicare's approved charge and the amount Medicare pays, your deductible and charges for any service not covered by Medicare. If you have supplemental insurance, we will bill it directly for you. You will receive a bill after your insurance has paid.

***HMO/PPO:*** **ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.** As the owner of your policy, you are responsible for verifying that we are an in-network provider under your plan. If you are an HMO member, you will not be billed as long as you have obtained the necessary referrals (also your responsibility).

***Insurance Disputes:*** If there is a dispute regarding the payment of your insurance or certain workers' compensation claim, ORNS has the right to bill you prior to the resolution of that dispute and to anticipate payment from you.

***I understand that the office agrees to bill insurance carrier as a courtesy to me. I must submit information as needed by my insurance company or ORNS to guarantee payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.***

X _____

Patient Signature

_____

Print Name/Signature of Authorized Representative/Relationship

X _____

Date

ORTHOPAEDICS AND RHEUMATOLOGY OF THE NORTH SHORE

**ORTHOPAEDICS**
EDWARD L. SCLAMBERG, M.D.
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4709 W. GOLF RD, SUITE 1200
SKOKIE, IL 60076

**RHEUMATOLOGY**
ERIN L. ARNOLD, M.D.
WILLIAM J. ARNOLD, M.D.
PHONE: 847-869-7233
FAX : 847-869-9461

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was developed to protect patients' rights and confidentiality in a healthcare environment that is becoming increasingly more technologically advanced. It serves to protect patient privacy, secure health information and enhance standards to improve privacy protections and security safeguards for consumer health data.

Patient Name: _____ DOB: _____

I acknowledge that I have received notice of HIPAA privacy practices for ORNS, and I would like the below listed individuals to be allowed as approved contacts for my account. I acknowledge that you may speak with them in regards to my patient information, treatment/care, appointments, and billing. I understand that I may revoke this authorization and update these approved contacts at any time.

1. _____
(Name / Relationship)

2. _____
(Name / Relationship)

3. _____
(Name / Relationship)

4. _____
(Name / Relationship)

5. _____
(Name / Relationship)

At times, we will contact patients in regards to appointments, treatment, questions and care. If we are able to leave a voicemail for you if you do not answer at the time, please indicate to which phone numbers this would be allowed.

_____cell _____home

_____work _____other

## Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

## Your Rights:

You have the following rights regarding Health Information we have about you:

***Right to Inspect and Copy.*** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Orthopaedics & Rheumatology of the North Shore, attention Medical Records. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

***Right to an Electronic Copy of Electronic Medical Records.*** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

***Right to Get Notice of a Breach.*** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

***Right to Amend.*** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Orthopaedics & Rheumatology of the North Shore, attention Supervisor.

***Right to an Accounting of Disclosures.*** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Orthopaedics & Rheumatology of the North Shore, attention Supervisor.

***Right to Request Restrictions.*** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Orthopaedics & Rheumatology of the North Shore, attention Supervisor. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

***Out-of-Pocket-Payments.*** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

***Right to Request Confidential Communications.*** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Orthopaedics & Rheumatology of the North Shore, attention Supervisor. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

***Right to a Paper Copy of This Notice.*** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.ornsmd.com. To obtain a paper copy of this notice, please stop by Orthopaedics & Rheumatology of the North Shore.

## Changes to This Notice:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

## Complaints:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Practice Manager. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

Orthopaedics & Rheumatology
of the North Shore
4709 W. Golf Road
Suite 1200
Skokie, Illinois 60076

POS Reorder # 1607156

# NOTICE OF PRIVACY PRACTICES

## ORTHOPAEDICS & RHEUMATOLOGY OF THE NORTH SHORE

**4709 W. GOLF ROAD**
**SUITE 1200**
**SKOKIE, ILLINOIS 60076**

*Effective Date:* September 23, 2013

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

If you have any questions about this notice, please contact Orthopaedics & Rheumatology of the North Shore, at 847.869.9461 and request to speak to a supervisor.

## Our Obligations:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

## How We May Use and Disclose Health Information:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

***For Treatment.*** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

***For Payment.*** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

***For Health Care Operations.*** We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the orthopaedic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

***Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.*** We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

***Individuals Involved in Your Care or Payment for Your Care.*** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

***Research.*** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

## Special Situations:

***As Required by Law.*** We will disclose Health Information when required to do so by international, federal, state or local law.

***To Avert a Serious Threat to Health or Safety.*** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

***Business Associates.*** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

***Organ and Tissue Donation.*** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

***Military and Veterans.*** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

***Workers' Compensation.*** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

***Public Health Risks.*** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

***Health Oversight Activities.*** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

***Data Breach Notification Purposes.*** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

***Lawsuits and Disputes.*** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

***Law Enforcement.*** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

***Coroners, Medical Examiners and Funeral Directors.*** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

***National Security and Intelligence Activities.*** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

***Protective Services for the President and Others.*** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

***Inmates or Individuals in Custody.*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

## Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt

***Individuals Involved in Your Care or Payment for Your Care.*** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

***Disaster Relief.*** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

ORTHOPAEDICS AND RHEUMATOLOGY OF THE NORTH SHORE

# RHEUMATOLOGY MEDICAL HISTORY

Name : _____

DOB : ____ /____ /____ Date : ____ /____ /____

Referring doctor : _____ Local pharmacy : _____

Address : _____ Address : _____

Phone : _____ Phone : _____

## PERSONAL HEALTH HISTORY

*Briefly state your reason for seeing the doctor today. Please describe your current symptoms, when it started, and what you have done for it:*

## REVIEW OF SYSTEMS

*Please use a check mark (√) to indicate whether you have had any of the conditions listed below over the LAST MONTH :*

| | | |
|---|---|---|
| **Constitutional** | **Respiratory** | ☐ Numbness or tingling of arms/legs |
| ☐ Fever | ☐ Shortness of breath | ☐ Muscle Weakness |
| ☐ Weight gain (>10 lbs) | ☐ Wheezing | ☐ Paralysis of arms/legs |
| ☐ Weight loss (>10 lbs) | ☐ Cough | ☐ Muscle pain, aches, or cramps |
| ☐ Feeling sickly | **Gastrointestinal** | ☐ Swelling of hands |
| ☐ Unusual Fatigue | ☐ Loss of appetite | ☐ Swelling of ankles |
| **Head / Eye / Ear / Nose / Throat** | ☐ Heartburn or stomach gas | ☐ Swelling in other joints |
| ☐ Headaches | ☐ Stomach pain or cramps | ☐ Joint pain |
| ☐ Dry eyes | ☐ Nausea | ☐ Back pain |
| ☐ Other eye problems | ☐ Vomiting | ☐ Neck pain |
| ☐ Fainting spells | ☐ Constipation | **Skin** |
| ☐ Problems with hearing | ☐ Diarrhea | ☐ Skin rash/hives |
| ☐ Ringing in the ears | ☐ Dark or bloody stools | ☐ Loss of hair |
| ☐ Stuffy nose | **Genitourinary** | ☐ Other Skin problems |
| ☐ Sores in the mouth | ☐ Problems with urination | **Psychiatric** |
| ☐ Swollen glands | ☐ Gynecological (female) problems | ☐ Depression – feeling blue |
| ☐ Dry mouth | ☐ Burning in sex organs | ☐ Anxiety – feeling nervous |
| ☐ Lump in your throat | ☐ Sexual problems | ☐ Problems with thinking |
| ☐ Problems with smell or taste | **Endocrine** | ☐ Problems with sleeping |
| ☐ Trouble swallowing | ☐ Unusual bruising or bleeding | ☐ Problems with memory |
| **Cardiovascular** | **Neurological** | ☐ Problems with social activities |
| ☐ Pain in chest | ☐ Dizziness | ☐ Smoking cigarettes |
| ☐ Heart pounding (palpitations) | ☐ Losing your balance | ☐ Use of drugs not sold in stores |
| | | ☐ More than 2 alcoholic drinks/day |

**Name:** _____

*Please list all major illnesses or hospitalizations (other than for operations):*

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

*Please list all operations that you have ever had :*

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

*Please use a check mark (√) to indicate whether you have had any of the conditions listed below :*

| Head / Eye / Ear / Nose / Throat | Gastrointestinal | Musculoskeletal |
|---|---|---|
| ☐ Dry eyes | ☐ Stomach ulcer | ☐ Back or spine problems |
| ☐ Cataracts | ☐ Other gastrointestinal problem | ☐ Osteoarthritis |
| ☐ Dry Mouth | **Genitourinary** | ☐ Rheumatoid arthritis |
| **Cardiovascular** | ☐ Kidney problem | ☐ Lupus |
| ☐ High blood pressure | ☐ Gynecological (female) problem | ☐ Fibromyalgia |
| ☐ Heart attack | ☐ Prostrate (male) problem | ☐ Broken bones after age 50 |
| ☐ Palpitations | **Endocrine** | ☐ Osteoporosis |
| ☐ Other heart disease | ☐ Diabetes | **Skin** |
| **Respiratory** | ☐ Thyroid disorder | ☐ Psoriasis |
| ☐ Asthma | **Hematologic** | ☐ Other skin disease |
| ☐ Severe allergies | ☐ Problems with blood clotting | **Psychiatric** |
| ☐ Emphysema | ☐ Cancer | ☐ Depression |
| ☐ Bronchitis | **Neurologic** | ☐ Alcoholism |
| ☐ History of tuberculosis | ☐ Stroke | ☐ Mental illness |
| ☐ Other respiratory disease | ☐ Parkinson's disease | ☐ Other: |

## MEDICATION HISTORY

*LIST YOUR PRESCRIBED DRUGS*

| Name of drug | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

*OVER THE COUNTER MEDICATIONS*

| Name of drug | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |

*ALLERGIES TO MEDICATIONS*

| Name the drug | Reaction you had |
|---|---|
| | |
| | |
| | |

Name: _____

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | **Children** | ☐ **M** ☐ **F** | |
| **Mother** | | | | ☐ **M** ☐ **F** | |
| **Sibling** | ☐ **M** ☐ **F** | | | ☐ **M** ☐ **F** | |
| | ☐ **M** ☐ **F** | | | ☐ **M** ☐ **F** | |
| | ☐ **M** ☐ **F** | | **Grandmother** ***Maternal*** | | |
| | ☐ **M** ☐ **F** | | **Grandfather** ***Maternal*** | | |
| | ☐ **M** ☐ **F** | | **Grandmother** ***Paternal*** | | |
| | ☐ **M** ☐ **F** | | **Grandfather** ***Paternal*** | | |

## SOCIAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| **HABITS** | | | | | |
| **Tobacco** | Do you use tobacco? | | | ☐ Yes | ☐ No |
| | ☐ Cigarettes – pks/day | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day | |
| | ☐ # of years | | ☐ Or years quit | | |
| **Alcohol** | Do you drink alcohol? | | | ☐ Yes | ☐ No |
| **Drugs** | Do you currently use recreational or street drugs? | | | ☐ Yes | ☐ No |
| **Occupation** | What is your current occupation? | | | | |
| | If retired, what was your past occupation? | | | | |
| **Exercise** | ☐ Sedentary (No exercise) | | | | |
| | ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | |
| | ☐ Occasional vigorous exercise (i.e., work or recreation less than 4x/week for 30 minutes) | | | | |
| | ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Cola | |
| | # of cups/cans per day | | | | |
| **Personal Safety** | Do you live alone? | | | ☐ Yes | ☐ No |
| | Do you have frequent falls? | | | ☐ Yes | ☐ No |
| | Do you have vision or hearing loss? | | | ☐ Yes | ☐ No |
| | Have you ever had a fracture (broken bone)? | | | ☐ Yes | ☐ No |
| **Females Only** | Have you gone through menopause? | | | ☐ Yes | ☐ No |
| | If YES, at what age? | | | | |
| **Bone Density** | Have you had a bone density test done? | | | ☐ Yes | ☐ No |
| | If YES, when and where was this done? | | | | |

*Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. <u>There are no right or wrong answers</u>. Please answer exactly as you think or feel.*

**Name:** _____

**1.) Please place a check mark (√) in the appropriate spot for the ONE best answer for your abilities at this time:**

| | **OVER THE LAST WEEK,** were you able to: | Without **ANY** Difficulty (0) | With **SOME** Difficulty (1) | With **MUCH** Difficulty (2) | **UNABLE** To Do (3) |
|---|---|---|---|---|---|
| a. | Dress yourself, including tying shoelaces and doing buttons? | | | | |
| b. | Get in and out of bed? | | | | |
| c. | Lift a full cup or glass to your mouth? | | | | |
| d. | Walk outdoors on flat ground? | | | | |
| e. | Wash and dry your entire body? | | | | |
| f. | Bend down to pick up clothing from the floor? | | | | |
| g. | Turn regular faucets on and off? | | | | |
| h. | Get in and out of a car, bus, train or airplane? | | | | |
| i. | Walk two miles or three kilometers, if you wish? | | | | |
| j. | Participate in recreational activities and sports as you would like? | | | | |

**2.) Please indicate how severe your pain has been because of your condition OVER THE PAST WEEK?**

| NO PAIN | O 0 | O 0.5 | O 1.0 | O 1.5 | O 2.0 | O 2.5 | O 3.0 | O 3.5 | O 4.0 | O 4.5 | O 5.0 | O 5.5 | O 6.0 | O 6.5 | O 7.0 | O 7.5 | O 8.0 | O 8.5 | O 9.0 | O 9.5 | O 10 | SEVERE PAIN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| | | | |
|---|---|---|---|
| When did the pain begin? | | | |
| What makes you feel better? | | | |
| Worse? | | | |
| Do you have pain at rest? ☐ Yes ☐ No | | Do you have pain with activity? ☐ Yes ☐ No | |

**3.) Please place a check mark (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:**

| | | None (0) | Mild (1) | Moderate (2) | Severe (3) | | | None (0) | Mild (1) | Moderate (2) | Severe (3) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Left Fingers | | | | | i. | Right Fingers | | | | |
| b. | Left Wrist | | | | | j. | Right Wrist | | | | |
| c. | Left Elbow | | | | | k. | Right Elbow | | | | |
| d. | Left Shoulder | | | | | l. | Right Shoulder | | | | |
| e. | Left Hip | | | | | m. | Right Hip | | | | |
| f. | Left Knee | | | | | n. | Right Knee | | | | |
| g. | Left Ankle | | | | | o. | Right Ankle | | | | |
| h. | Left Toes | | | | | p. | Right Toes | | | | |
| q. | Neck | | | | | r. | Back | | | | |

**4.) Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:**

| VERY WELL | O 0 | O 0.5 | O 1.0 | O 1.5 | O 2.0 | O 2.5 | O 3.0 | O 3.5 | O 4.0 | O 4.5 | O 5.0 | O 5.5 | O 6.0 | O 6.5 | O 7.0 | O 7.5 | O 8.0 | O 8.5 | O 9.0 | O 9.5 | O 10 | VERY POORLY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐Yes ☐No
If "Yes", please indicate the number of minutes _____ or hours _____ until you are as limber as you will be for the day

How you feel TODAY compared to ONE WEEK AGO? Please check only one.
☐ Much better ☐ Better ☐ The Same ☐ Worse ☐ Much Worse

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

| NO PROBLEM | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 | MAJOR PROBLEM |
|---|---|---|---|---|---|---|---|---|---|---|---|---|