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

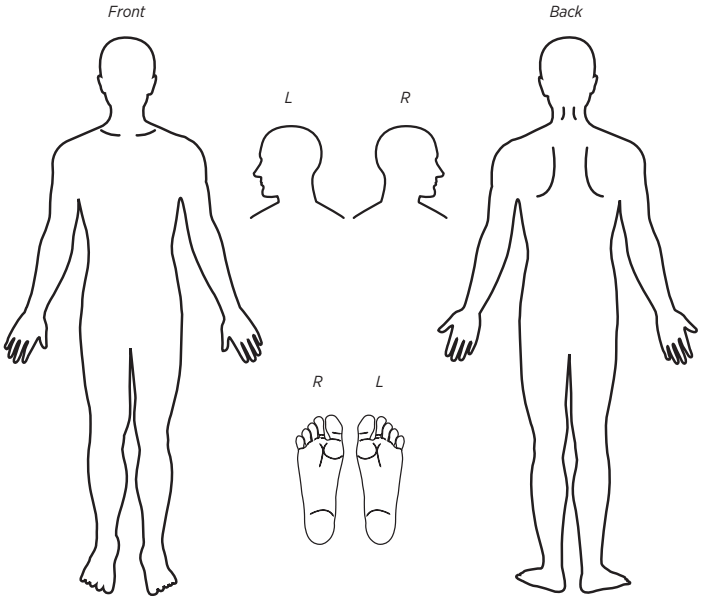
Height: _____ Weight: _____

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	☐ Effective	☐ Not effective
Chiropractor	☐ Effective	☐ Not effective
Biofeedback	☐ Effective	☐ Not effective
Anti-inflammatories	☐ Effective	☐ Not effective
Injections	☐ Effective	☐ Not effective
Anti-depressants	☐ Effective	☐ Not effective
Sedatives/Narcotics	☐ Effective	☐ Not effective
Physical therapy	☐ Effective	☐ Not effective

Over >

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	☐ No	☐ Yes
Loss of appetite	☐ No	☐ Yes
Fever/chills	☐ No	☐ Yes
Double/blurred vision	☐ No	☐ Yes
Ringing in ears	☐ No	☐ Yes
Bloody nose/gums	☐ No	☐ Yes
Sore throat	☐ No	☐ Yes
Chest pain	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Cough	☐ No	☐ Yes
Speech	☐ No	☐ Yes
Leg/arm weakness	☐ No	☐ Yes
Blood in stool	☐ No	☐ Yes
Constipation/diarrhea	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Abdominal pain	☐ No	☐ Yes
Change in bladder habits	☐ No	☐ Yes
Rashes	☐ No	☐ Yes
Bruises	☐ No	☐ Yes
Headache	☐ No	☐ Yes
Dizziness	☐ No	☐ Yes
Blackouts	☐ No	☐ Yes
Numbness/tingling	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Pain in other joints?	☐ No	☐ Yes

If yes, please list: _____

_____

Past medical history includes:

High blood pressure	☐ No	☐ Yes
Peptic ulcer	☐ No	☐ Yes
Frequent infections	☐ No	☐ Yes
Bleeding problems	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Anesthesia problems	☐ No	☐ Yes
Liver disease	☐ No	☐ Yes
Rheumatoid arthritis	☐ No	☐ Yes
Cardiac disease	☐ No	☐ Yes
Angina	☐ No	☐ Yes
Thyroid	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Sleep apnea/c-pap	☐ No	☐ Yes
Blood clot	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Emphysema	☐ No	☐ Yes
Depression/anxiety	☐ No	☐ Yes
Asthma	☐ No	☐ Yes

Other medical conditions:_____

_____

_____

Family history of:

Rheumatoid arthritis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Heart disease	☐ No	☐ Yes

Medication form

Main Line HealthCare
Physician Network

PATIENT INFORMATION

Name:_____ Date of birth: _____

DRUG ALLERGIES

Please list all drug allergies and describe reaction: _____

_____

_____

CURRENT MEDICATIONS

Pharmacy name:_____ Phone number: _____

Medication	Dose	Frequency

_____

Scott A. Rushton, MD Date

MLHC.08-20.CM.0910

Registration form

Main Line HealthCare
Physician Network

PATIENT INFORMATION

Name:_____

Address:_____

_____

Home #: _____

Work #: _____

Cell #:_____

Employer:_____

Employer address: _____

_____

Who referred you? _____

Referring phone #: _____

Referring address: _____

Social Security #: _____

Date of birth: _____

Age: _____ Sex: ☐ Male ☐ Female

Allergies: _____

Email: _____

Marital status:
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Emergency contact: _____

Relationship: _____

Phone #:_____

Primary/family doctor: _____

Physician: _____

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: _____

Address:_____

Phone #:_____

ID #: _____

Group: _____ Effective date: _____

Policyholder: _____

Relationship:_____ DOB:_____

Employer:_____

Address:_____

Secondary insurance: _____

Address:_____

Phone #:_____

ID #: _____

Group: _____ Effective date: _____

Policyholder: _____

Relationship:_____ DOB:_____

Employer:_____

Address:_____

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

Insurance:_____

Address:_____

Claim #: _____

Accident date: _____

State where accident occurred: _____

Adjuster phone #:_____

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

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