PROFESSIONAL ORTHOTIC
& PROSTHETIC SERVICES

Patient ID Number _____ Today's Date ____/____/____

Section 1 - General Patient Information

1) First Name _____ Middle Name _____ Last Name _____ Preferred Name _____

2) Date of Birth ____/____/____ **3)** Gender: ☐ Male ☐ Female **4)** Social Security Number ___-___-____

5) E-mail Address _____

6) Vocational Category

☐Employed Full Time	☐Employed Part Time	☐Student Full Time	☐Student Part Time
☐Homemaker	☐Unemployed	☐On Disability	☐On Leave of Absence
☐Retired	☐Pediatric Patient	☐Other	

7) Driver License Number and State _____ **8)** Preferred Language _____

9) Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

10) Hispanic/Latino: ☐Yes ☐No ☐Prefer Not to Answer

11) Race

☐American Indian or Alaskan Native	☐Native Hawaiian or Other Pacific Islander	☐Asian
☐White	☐Black or African American	☐Other
☐Prefer Not to Answer		

12) Highest Level of Education Achieved

☐Some High School	☐High School/GED	☐Some College or Tech Degree
☐College Degree	☐Graduate Degree	☐Prefer Not to Answer

13) Armed Forces Service

☐Active Service Member	☐Reserve Service Member	☐Veteran
☐Not a Member	☐Prefer Not to Answer	

14) If you have served, in what branch did you serve? ☐Air Force ☐Army ☐Coast Guard ☐Marines ☐Navy

15) Please check beside your preferred contact phone number.
☐ Home Phone _____ ☐ Mobile Phone _____ ☐ Work Phone _____

16) Is it okay to leave a message on your voicemail? ☐ Yes ☐ No

17) Home Address: _____
City _____ State _____ Zip Code _____

18) Are you currently admitted to a hospital, rehabilitation center, or nursing facility? ☐ Yes ☐ No

Section 2 - Patient Contacts

1) Responsible Party ☐ Patient is the responsible party

Name _____ E-mail Address _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Other

Home Phone _____ Mobile Phone _____ Work Phone _____

Home Address _____ ☐ Address Same as Patient

City _____ State _____ Zip Code _____

2) Emergency Contact ☐ Emergency contact same as responsible party

Name _____ Relationship to Patient _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Home Address _____ ☐ Address Same as Patient

City _____ State _____ Zip Code _____

Section 3 - Insurance Information

1) Is this a workman's compensation case? ☐ Yes ☐ No

Case Manager's Name _____ Case Manager Phone Number _____

2) Primary Insurance Company _____

ID Number _____ Group Number _____

Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

**If patient is not the subscriber, please complete the subscriber information section below.*

3) Secondary Insurance Company _____

ID Number _____ Group Number _____

Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

**If patient is not the subscriber, please complete the subscriber information section below.*

4) Subscriber Name _____ Subscriber Employer _____

Date of Birth ___/___/___ Gender: ☐ Male ☐ Female Social Security Number ___-___-___

Home Phone _____ Mobile Phone _____ Work Phone _____

Home Address: _____

City _____ State _____ Zip Code _____

Section 4 – Prescription Information

1) How did you hear about our facility? ☐ Referring Physician ☐ Friend or Relative
☐ Therapist ☐ Insurance Company ☐ Other: _____

2) What general category of service/device are you coming in for today?
☐ Orthosis (orthopedic brace or footwear) ☐ Prosthesis (artificial limb)

3) Which area of the body? ☐ Arm ☐ Leg ☐ Torso ☐ Other

4) Which side? ☐ Left ☐ Right ☐ Both ☐ N/A

5) Name of Referring Physician	Group or Practice Name	Phone Number
_____	_____	_____
6) Name of Primary Care Physician	Group or Practice Name	Phone Number
_____	_____	_____
7) Name of Physical Therapist	Group or Practice Name	Phone Number
_____	_____	_____

Section 5 - Patient Medical History

1) Height _____

2) Weight _____ Recent changes in weight? ☐ Yes ☐ No
☐ Gained ☐ Lost _____ lbs

3) Tobacco Use:
☐ Currently Use Tobacco Type of Tobacco Used? _____
☐ Used, but Quit When did you quit? _____
☐ Never Used
☐ Prefer Not to Answer

4) Falls in the Last 6 Months? ☐ Yes If yes, how many? _____ ☐ No

5) Have you been hospitalized, to the emergency room, to an urgent care center, or in any type of care facility in the last 6 months? ☐ Yes ☐ No
If yes, was it related to a fall? ☐ Yes ☐ No
Details: _____

6) General Health ☐ Poor ☐ Fair ☐ Good ☐ Excellent

7) Activity Level ☐ Sedentary ☐ Limited Activity ☐ Active ☐ Very Active

8) Please check all that apply:
☐Your condition is a result of an accident from employment
☐Your condition is a result of an auto accident
☐Your condition is a result of any other type of accident
☐I have had this condition since birth

9) If your condition is the result of an accident or injury:
Date of accident/injury ____/____/____ State where accident occurred _____
Description of accident _____

10) Have you received any orthotics or prosthetic device(s) within the past five years? ☐ Yes ☐ No
If so, please list item(s) and date.

11) Have you had an amputation? ☐ Yes ☐ No
Location of Amputation: _____ Date of Amputation: _____
Reason for Amputation: _____

12) List any known allergies (including contact materials).

13) List any medications you are currently taking.

Medication	Dosage	Frequency

14) Please list all major surgeries and their dates.

Surgery	Date of Surgery

15) Have you had or do you have any of the following? Please check all that apply.

☐Alcoholism	☐High Blood Pressure	☐Pacemaker/Defibrillator
☐Alzheimer's or Dementia	☐HIV	☐Parkinson's Disease
☐Anxiety	☐Infections	☐Currently Pregnant
☐Asthma	☐Intestinal Problems	☐Psychiatric Problems
☐Brain Injury/TBI	☐Kidney Disease	☐Pulmonary Disease (TB)
☐Cancer	☐Liver Disease	☐Rheumatoid Arthritis
☐Depression	☐Migraines	☐Seizure Disorders
☐Diabetes Type I	☐MRSA	☐Skin Problems
☐Diabetes Type II	☐Neurological Problems	☐Stomach Problems
☐Hearing Loss	☐Obesity	☐Stroke/TIA/CVA
☐Heart Problems	☐Osteoarthritis	☐Vascular Disease
☐Hepatitis A B or C (please circle)	☐Osteoporosis	☐Vision Problems

16) List any other conditions you feel might affect your treatment.