SPORTS & OCCUPATION
MEDICAL ASSOCIATES

Norman J. Kahan, M.D.
Physical Medicine & Rehabilitation

Julia S. Kahan, M.D.
Orthopedic Surgery

PATIENT INTAKE QUESTIONNAIRE

AGE ____________

1. NAME ______________________ LIST EMAIL OR CHECK BOX TO OPT OUT: ☐ ______________________________

2. NAME OF LOCAL PHARMACY & CROSS STREET ______________________________________

3. WHO REFERRED YOU TO OUR OFFICE? ______________________________________

4. WHO IS YOUR PRIMARY CARE PHYSICIAN? ______________________________________

5. WHAT IS THE MAIN REASON FOR YOUR VISIT: CIRCLE: [RIGHT OR LEFT] ______________________________
____
____

6. PLEASE NOTE THE DATE OF INJURY OR ESTIMATE THE ONSET OF SYMPTOMS ____________________

7. HOW & WHERE WERE YOU INJURED? ______________________________________
____

8. DO YOU SUFFER FROM ANY OTHER OF THE FOLLOWING CONDITIONS? Check all that apply:

__HIGH BLOOD PRESSURE
__BLOOD CLOTS
__DIABETES [TYPE-1 or TYPE-2]
__GOUT
__OSTEOARTHRITIS
__HEART DISEASE
__THYROID DISORDER
__DEPRESSION
__ULCER
__BLEEDING DISORDER
__HEART MURMUR
__HEARTBURN
__EMPHYSEMA
__ASTHMA
__NAUSEA
__ATRIAL FIBRILLATION
__HIGH CHOLESTEROL
__MIGRAINES
__ARTHRITIS
__CATARACTS
__HEART ATTACK
__KIDNEY DISEASE
__HEPATITIS
__SEIZURES
__BLADDER DISEASE
__STROKE
__OSTEOPOROSIS
__TB EXPOSURE
__CANCER
__OTHER ____

9. LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME OF MEDICATION	DOSAGE	FREQUENCY

10. LIST ALL MEDICATION ALLERGIES:

NAME OF MEDICATION	REACTION/SIDE EFFECT

320 Dardanelli Lane, Suite 27B, Los Gatos, California 95032 Phone (408) 374-1112 Fax (408) 374-1133 www.drskahan.org

11. LIST SURGICAL HISTORY:

TYPE OF SURGERY	APPROX. DATE OF SURGERY

12. DO YOU HAVE A PACEMAKER? ___ Yes ___ No

13. HAVE YOU HAD STENTS PLACED? ___ Yes ___ No

14. PLEASE PUT A CHECK NEXT TO ANY OF THE FOLLOWING BELOW THAT YOU ARE EXPERIENCING:

REVIEW OF SYSTEMS:

Constitutional:
__ Fever
__ Night Sweats
__ Weight Loss
__ Chills

Eyes:
__ Failing vision
__ Double vision
__ Blurred vision

Genitourinary:
__ Burning of urination
__ Difficulty starting or ending stream
__ Sexual Dysfunction
__ Frequency of urination
__ # of times I awake at night to urinate(#___)
__ Loss of bladder control
__ Number of pregnancies (#____)
__ Number of live children(#____)

Immunologic:
__ Frequent infections
__ AIDS
__ Allergies to environmental agents
__ Allergies to foods:
____
____
____
____

Gastrointestinal:
__ Abdominal Pain
__ Nausea
__ Vomiting
__ Heartburn
__ Change in bowel habits
__ Hepatitis history

Ears, Nose & Throat:
__ Hearing loss
__ Ringing in ears
__ Decreased ability to taste
__ Difficulty swallowing
__ Hoarseness
__ Nasal drainage
__ Sensation of spinning

Endocrine:
__ Discharge from nipples
__ Poor appetite
__ Cold intolerance
__ Excessive thirst
__ Weight gain

Psychiatric:
__ Depression
__ Anxiety
__ Nervous breakdown
__ Alcohol problem
__ Drug problem

Cardiovascular:
__ Shortness of breath
__ Chest pain
__ Irregular heartbeat
__ Ankle swelling
__ Heart defect
__ Need to take abx for dental work

Musculoskeletal:
__ Leg cramps
__ Swelling
__ Aching joints
__ Weakness
__ Jerking of legs

Respiratory:
__ Chronic cough
__ Coughing blood or sputum
__ Asthma
__ Recurring bronchitis

Neurological:
__ Headaches
__ Seizures
__ Poor coordination
__ Dizziness
__ Frequent falling
__ Memory problems
__ Personality Changes
__ Tremor

Blood:
__ Bleeding tendencies
__ Blood transfusion
__ Easy bruising

Skin:
__ Dry skin
__ Rash
__ Sores

Other:
____
____
____
____
____
____

15. Do you smoke? ________ **For how long?** ____________ **How often?** __________ **cigarettes per day.**

16. Do you drink alcohol? _________ **How often?** __________ **glass(es)** [per day or per week] (circle one)

17. ARE YOU RIGHT OR LEFT HANDED? ________________

18. FAMILY MEDICAL HISTORY:

	LIVING	DECEASED	RELATED ILLNESS/CAUSE OF DEATH
MOTHER			
FATHER			
SISTER			
BROTHER			
AUNT			
UNCLE			

19.* PHYSICAL EXAM/VITALS:

*HEIGHT	
*WEIGHT	
BMI	
TEMPERATURE	
HEART RATE	
RESPIRATORY RATE	
BLOOD PRESSURE	

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LAST NAME	FIRST NAME	MIDDLE	DATE OF BIRTH	AGE

STREET ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY NUMBER

HOME PHONE	WORK PHONE	MARITAL STATUS
( )	( )	M S D W

EMPLOYER NAME	OCCUPATION	SEX
		☐ MALE ☐ FEMALE

EMPLOYER ADDRESS	CITY	STATE	ZIP

SPOUSE OR PARENT'S NAME	SOCIAL SECURITY NUMBER	DRUG ALLERGIES : PLEASE LIST

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE
		( )	( )

INSURANCE INFORMATION PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST

INSURANCE COMPANY	SUBSCRIBER	RELATIONSHIP AND D.O.B.

CLAIM ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

IDENTIFICATION NUMBER	GROUP NUMBER

HISTORY OF PROBLEM

PART OF BODY	DATE OF INJURY/ONSET OF SYMTOMS
☐ LEFT ☐ RIGHT	

WERE YOU INJURED ON THE JOB? YES NO *IF YES, PLEASE FILL OUT NEXT SECTION	WERE YOU INJURED DUE TO AN ACCIDENT? YES NO

WORK RELATED INJURIES

NAME OF COMPENSATION INSURANCE CARRIER	CLAIM ADJUSTER	PHONE NUMBER

INSURANCE CARRIERS ADDRESS CITY STATE ZIP	INDUSTRIAL CLAIM NUMBER	DATE OF INJURY

AUTHORIZATION GIVEN BY :	PHONE NUMBER	EMPLOYER (AT TIME OF INJURY)

AUTHORIZATION FOR : ☐ EVALUATION ☐ TREATMENT ☐ 2ND OPINION ☐ QME ☐ AME ☐ OTHER________________

REFERRED BY :	TITLE/RELATIONSHIP

ADDRESS CITY STATE ZIP	PHONE NUMBER

I hereby authorize Sports & Occupation Medical Associates to release information regarding my treatment to my insurance company or its representatives. I also authorize payment to be made directly to Sports & Occupation Medical Associates for all charges rendered by myself or my dependents. I understand that I am responsible for any amounts not covered by my insurance company. Should my account be referred to an attorney for collection, I shall pay actual attorney's fees and collection expense.

SIGNATURE_________________________________ DATE__________

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To Our Patients,

We participate in and are providers for numerous insurance programs as a convenience to our patients. Our goal as always, is to provide our patients with the best care possible. In this day and age of managed health care each program has their own rules and regulations that must be followed and unfortunately that information is not always readily accessible to the physician/provider.

We can at the time of your first contact with the office or at your initial appointment tell you if we participate with your insurance company. We will then gladly have our billing service bill your primary insurance for you. However, the ultimate responsibility for knowing what your insurance requires lies with you. For example, your insurance may require that you be referred only to a particular lab for blood work or that you have your prescriptions only through a particular pharmacy. This is information that should be provided to you as the consumer, which you then will need to pass on to us as the need arises. We ask that you familiarize yourself with your insurance policy and any special requirements. We will certainly do our best to meet your insurance guidelines and regulations.

Your copay is due at the time of your visit or a $10.00 administration fee will be applied to your balance.

I understand that I am responsible for providing all necessary information regarding my insurance and any special needs that I might require.

Signed____

Date____

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Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have read a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the receptionist area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed:________________________________ **Date:**________________________

Print Name:____________________________ Telephone:____________________

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor parent
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased parent

Name of Patient:____

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