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? _____

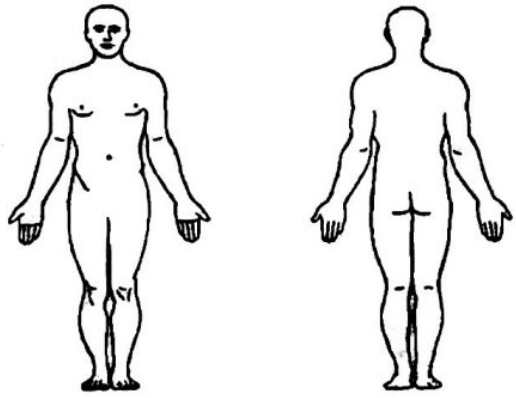
4. WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

5. WHAT IS THE MAIN REASON FOR YOUR VISIT: _____

6. Circle all that apply:

NECK	Right / Left	SHOULDER	Right / Left
MID BACK	Right / Left	FOREARM	Right / Left
LOW BACK	Right / Left	ELBOW	Right / Left
HAND	Right / Left	WRIST	Right / Left
FINGER(S)	Right / Left (1 2 3 4 5)		
HIP	Right / Left	KNEE	Right / Left / Front / Back
PELVIS	Right / Left	CALF	Right / Left
THIGH	Right / Left	ANKLE	Right / Left
FOOT	Right / Left / Top / Bottom		
TOE(S)	Right / Left (1 2 3 4 5)		

7. MARK FIGURES BELOW TO INDICATE AREA OF PAIN:



8. PLEASE NOTE THE DATE OF INJURY OR ESTIMATE THE ONSET OF SYMPTOMS _____

9. HOW & WHERE WERE YOU INJURED? _____

_____

10. 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	__ CATARATS
__HEART ATTACK	__KIDNEY DISEASE	__HEPATITIS	__SEIZURES	__BLADDER DISEASE
__STROKE	__OSTEOPOROSIS	__ TB EXPOSURE	__CANCER	

__OTHER _____

11. LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME OF MEDICATION	DOSAGE	FREQUENCY

12. LIST ALL MEDICATION ALLERGIES:

NAME OF MEDICATION	REACTION/SIDE EFFECT

13. LIST SURGICAL HISTORY:

TYPE OF SURGERY	APPROX. DATE OF SURGERY

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

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

16. 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:

_____
_____
_____
_____
_____
_____

17. Do you smoke? _____ **For how long?** _____ **How often?** _____ **cigarettes per day.**

18. Do you drink alcohol? _____ **How often?** _____ **glass(es) per day** *or* **per week.** (circle one)

19. ARE YOU RIGHT OR LEFT HANDED? _____

20. FAMILY MEDICAL HISTORY:

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

21. ** 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_____

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

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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:_____