McCleve Orthotics & Prosthetics

NAME: (First, Middle, Last)

PREFERRED NAME:

TODAY'S DATE: ____/ ____/ ____

DATE OF BIRTH: ____ / ____ /____

☐ Male ☐ Female

SOCIAL SECURITY #: (OPTIONAL) ______ - _______ -_________

MARITAL STATUS: (circle) S M D W

SPOUSE/PARTNERS NAME: ____________________________

PHONE: (____) _______- ___________

EMAIL: (this is NOT for advertising)

VOCATIONAL CATEGORY: (circle)

Employed Full Time / Employed Part Time / Retired / Unemployed / Homemaker / On Disability / Student

AZ ADDRESS:

____

Apt/Lot: ______________________________

City: ________________________________

State: ______________ Zip: ____________

DO YOU LEAVE FOR THE SUMMER/WINTER? YES NO

WHAT MONTHS ARE YOU IN AZ? _________ TO ________.

OUT OF STATE/COUNTRY ADDRESS:

____

____

HOME NUMBER: (_____) _____ - ___________.

WORK NUMBER: (_____) _____ - ___________.

CELL NUMBER: (_____) _____ - ___________.

OTHER NUMBER: (_____) _____ - ___________.

DO YOU PREFER TO BE CONTACTED BY?

___ TEXT ___ EMAIL ___ MAIL

___ PHONE CALL ___ FAX

DO WE HAVE PERMISSION TO LEAVE A VOICEMAIL?

___ YES OR ___ NO

EMERGENCY CONTACT NAME: ________________________

RELATIONSHIP: ________________

EMERGENCY CONTACT'S PHONE NUMBER (_____) _____ - ___________.

EMERGENCY CONTACT NAME: ________________________

RELATIONSHIP: ________________

EMERGENCY CONTACT'S PHONE NUMBER (_____) _____ - ___________.

DOCTOR'S INFORMATION

REFERRING PHYSICIAN: ____________________	PHONE: (____) ______-________	PRIMARY CARE PHYSICIAN: ____________________	PHONE: (____) ______-________
SURGEON: (IF APPLICABLE) ____________________	PHONE: (____) ______-________	DIABETIC DR: (IF APPLICABLE) ____________________	PHONE: (____) ______-________
WHEN WAS YOUR LAST DOCTORS APPOINTMENT? ______ / ______ / ________		WHO WAS THE APPOINTMENT WITH? ____________________	

INSURANCE INFORMATION

AN INSURANCE CARD IS NOT NEEDED TO COMPLETE THE FOLLOWING

PRIMARY INUSURANCE: (card is not needed for the following information)

Company: ________________________ Subscriber Name: ____________________

Relationship: ______________________ * Subscriber Date of Birth: ________________

SECONDARY INSURANCE: (card is not needed for the following information)

Company: ________________________ Subscriber Name: ________________

Relationship: ______________________ * Subscriber Date of Birth: ________________

TERTIARY INSURANCE: (card is not needed for the following information)

Company: ________________________ Subscriber Name: ________________

Relationship: ______________________ * Subscriber Date of Birth: ________________

Accident/ Workman's Comp Insurance: Injury: ________________ Injury Date: ______________

Claim Number: ________________________ Adjusters Name: ______________ #: (____) _____-_______

Employer: ___________________________ Employer's Phone # :(______) ______-________

Medical History

Name: ______________________________ Weight: _____lbs Height: ____' ____"

How is your general health? : Poor Fair Good Excellent

Please circle your activity level: Low Medium Active Highly Active

Please check all that apply:

- Your injury is a result of an accident from employment.
- Your injury is a result of an auto accident.
- Your injury is a result of any other type of accident.

Injury Date: ___/___/___ (if applicable) The state where injury occurred ________ (AZ, CA, WY, ECT...)

PATIENT NARRATIVE- Please explain how the injury occurred OR the reason for your visit:

____

____

____

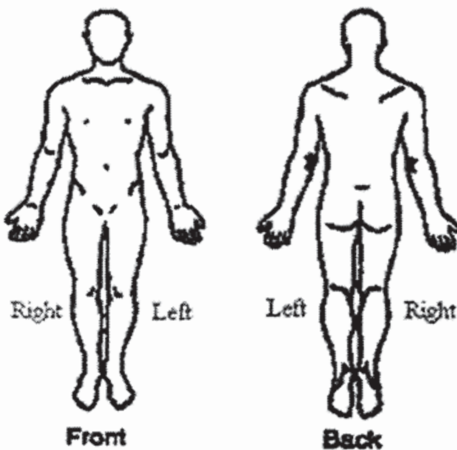
AMPUTATION: Yes ☐ (please check the following) No ☐ RIGHT ☐ LEFT ☐

Level:

__ Partial Foot	__ Hip Disarticulation	__Transhumeral (Above Elbow)
__Transtibial (Below Knee)	__Transradial (Below Elbow)	__ Shoulder Disarticulation
__Transfemoral (Above Knee)	__ Elbow Disarticulation	__ Other: ________________

Do you have or have had any of the following:

__Heart Problems	__Hepatitis A or B	__Vision Problems	__Pacemaker/Defibrillator
__Hypertension	__Hepatitis C	__Parkinson Disease	__Seizure Disorder
__Vascular Disease	__HIV Positive	__Alzheimer Disease	__Hearing Loss
__Stroke	__Rheumatoid Arthritis	__Psychiatric Problems	__Currently Pregnant
__Diabetes	__Obesity	__Alcoholism	__MRSA
__Kidney Disease	__Osteoarthritis	__Known Allergies: (latex/ polypropylene/ plastic/ silicone)	
__Osteoporosis	__Pulmonary Disease (TB)	______________________________	



Please circle or point to the area you are feeling pain.

On a scale of 1- 10 how bad is your pain?

1 2 3 4 5 6 7 8 9 10

Better Worse

Recent change in weight?

☐ Yes ☐ No

☐ Loss OR ☐ Gain

If you marked yes, please specify

____

____