



W: WCMIOOrtho.com  
P: 352-556-4823  
F: 352-556-4824

Welcome to the West Coast Musculoskeletal Institute. We would like to thank you for allowing us to care for your orthopedic condition. Please help us service your needs by answering the questions below regarding your situation.

- Is your injury/pain related to your **Employment**?       Yes       No
- Is your injury/pain related to an **Accident**?       Yes       No
- Is your injury/pain related to a **Law Suit**?       Yes       No
- Is there an **Attorney** related to this injury/pain?       Yes       No

If yes, please list the name, address and phone number:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- If you have answered yes to any of the above questions, please see the receptionist (or call the scheduling department if forms were downloaded from the website) before completing the remaining paperwork.

**ESTABLISHED PATIENT – NEW CASE INFORMATION:**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  M  F

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Are you:  Right-handed  Left-handed

Preferred Pharmacy (with cross streets): \_\_\_\_\_

**INSURANCE INFORMATION:**

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Claims Address: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Parent of Minor/Legal Representative      Date of Birth      Date



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Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**ONLY IF PATIENT IS A MINOR – RESPONSIBLE PARTY INFORMATION – Please fill in ALL blanks.**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex:  M  F DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

**Minor Pre-Authorization for Medical Care**

I request and authorize West Coast Musculoskeletal Institute and its personnel to deliver medical care to my child listed above.

Guardian Name (Print): \_\_\_\_\_ Guardian's Signature: \_\_\_\_\_

Relationship to Patient (Print): \_\_\_\_\_ Date: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Age: \_\_\_\_\_ Problem with:  Right Extremity  Left Extremity

Why are you here today? \_\_\_\_\_

**SYMPTOMS:**

Location: \_\_\_\_\_

(Where is the pain? Does it travel to other areas?)

Quality: \_\_\_\_\_

(Is the pain dull, throbbing, sharp? If a bump, is it warm, tender, red?)

Severity: \_\_\_\_\_

(How severe on a scale of 1 to 10, with 10 being the most severe?)

Duration: \_\_\_\_\_

(How long have you had this pain/problem? When did it start?)

Time: \_\_\_\_\_

(Does the pain/problem occur at a specific time? Is it rare, intermittent, constant?)

Context: \_\_\_\_\_

(What were you doing at the onset of the pain/problem?)

Associated signs/symptoms: \_\_\_\_\_

(Do you have numbness? Abnormal sounds like cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain?)

Modifying factors: \_\_\_\_\_

(What makes the problem worse or better? Example: Activities)

**PAST HISTORY OF PRESENT ILLNESS:**

Have you ever experienced any injury or symptoms regarding this body part?  Yes  No

If so, please provide details: \_\_\_\_\_

Please list any hobbies/sports you enjoy: \_\_\_\_\_

Which of the above activities are you unable to perform due to your pain? \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Have you seen any other physicians regarding THIS condition prior to coming to our office?  Yes  No

<u>Doctor</u>	<u>When</u>	<u>Tests</u>	<u>Results</u>	<u>Treatment</u>

**PAST MEDICAL HISTORY:**

<input type="checkbox"/> AIDS or HIV	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> COPD	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dementia	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Back Trouble	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Infectious Mono	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Other (Please List)
<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> _____
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Measles	<input type="checkbox"/> Smallpox	<input type="checkbox"/> _____
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> Stroke	<input type="checkbox"/> _____

Please list **all medications** you are taking (Include non-prescription and herbal supplements):

<u>Drug Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Drug Name</u>	<u>Dosage</u>	<u>Frequency</u>

**Are you allergic to any medications?**

<u>Medication</u>	<u>Reaction</u>

Tape Allergy:  Yes  No

Latex Allergy:  Yes  No

**Past Surgical/Hospitalization History:**

<u>Date</u>	<u>Surgery/Illness</u>	<u>Doctor</u>	<u>Hospital, City, State</u>

**PATIENT SOCIAL HISTORY:**

<u>Marital Status</u>	<u>Use of Alcohol</u>	<u>Use of Tobacco</u>	<u>Living Situation</u>
<input type="checkbox"/> Single	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> With family
<input type="checkbox"/> Married	<input type="checkbox"/> Rarely	<input type="checkbox"/> Previously, but quit	<input type="checkbox"/> With friends
<input type="checkbox"/> Divorced	<input type="checkbox"/> Moderate	<input type="checkbox"/> Currently:	<input type="checkbox"/> Alone
<input type="checkbox"/> Widow	<input type="checkbox"/> Daily	_____ packs a day	<input type="checkbox"/> Other: _____

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

Age	Conditions or Diseases	If Deceased, Cause of Death
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	_____
_____	_____	_____

**REVIEW OF SYSTEMS: Please indicate any personal history below:**

**Musculoskeletal**

- Joint pain  No  Yes
- Joint stiffness or swelling  No  Yes
- Weakness of muscles/joints  No  Yes
- Muscle pain or cramps  No  Yes
- Back pain  No  Yes
- Cold extremities  No  Yes
- Difficulty in walking  No  Yes

**Constitutional Symptoms**

- Bad general health lately  No  Yes
- Recent weight change  No  Yes
- Fever  No  Yes
- Fatigue  No  Yes
- Headache  No  Yes

**Ear/Nose/Mouth/Throat**

- Hearing loss or ringing  No  Yes
- Earaches or drainage  No  Yes
- Chronic sinus problems  No  Yes
- Nose bleeds  No  Yes
- Bleeding gums  No  Yes
- Sore throat or voice change  No  Yes
- Swollen glands in neck  No  Yes

**Cardiovascular**

- Heart trouble  No  Yes
- Chest pain or angina  No  Yes
- Palpitations  No  Yes
- Shortness of breath while walking  No  Yes
- Swelling of feet, ankles or hands  No  Yes

**Genitourinary**

- Frequent urination  No  Yes
- Burning or painful urination  No  Yes
- Blood in urine  No  Yes
- Incontinence or dribbling  No  Yes
- F-number of pregnancies \_\_\_\_\_
- F-number of deliveries \_\_\_\_\_

**Integumentary (skin, breast)**

- Rash or itching  No  Yes
- Changes in skin color  No  Yes
- Varicose veins  No  Yes
- Breast pain  No  Yes
- Breast lump  No  Yes

**Neurological**

- Light headed or dizziness  No  Yes
- Numbness/tingling sensations  No  Yes
- Tremors  No  Yes
- Paralysis  No  Yes

**Hematologic/Lymphatic**

- Bleeding/bruising tendency  No  Yes
- Anemia  No  Yes
- Enlarged glands  No  Yes
- Slow to heal after cuts  No  Yes

**Endocrine**

- Excessive thirst or urination  No  Yes
- Heat or cold intolerance  No  Yes
- Dry Skin  No  Yes

**Psychiatric**

- Memory loss or confusion  No  Yes
- Nervousness/Anxiety  No  Yes
- Depression  No  Yes
- Insomnia  No  Yes

**Gastrointestinal**

- Loss of appetite  No  Yes
- Nausea or vomiting  No  Yes
- Frequent diarrhea  No  Yes
- Constipation  No  Yes
- Rectal bleeding/blood in stool  No  Yes
- Abdominal pain  No  Yes

**Respiratory**

- Chronic or frequent coughs  No  Yes
- Spitting up blood  No  Yes
- Shortness of breath  No  Yes
- Wheezing  No  Yes

**Eyes**

- Eye disease or injury  No  Yes
- Wear glasses/contacts  No  Yes
- Blurred or double vision  No  Yes

**Allergic/Immunologic**

List food/environmental allergies:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Patients 65 or older: Spiritual/Cultural Preference?** \_\_\_\_\_

**Healthcare Proxy?**  Yes  No **Name:** \_\_\_\_\_

**Power of Attorney for Healthcare?**  Yes  No **Name:** \_\_\_\_\_

**Copy of POA?**  Yes  No **Do Not Resuscitate?**  Yes  No

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

\_\_\_\_\_  
Signature of Patient/Parent of Minor/Legal Representative

\_\_\_\_\_  
Date



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**PATIENT PRIVACY QUESTIONNAIRE**

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____	Name: _____
Address: _____	Address: _____
Phone Number: _____	Phone Number: _____
Relationship: _____	Relationship: _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name: _____	Phone #: _____
Name: _____	Phone #: _____

I understand that all correspondence from our office will be sent in a sealed envelope marked **"CONFIDENTIAL"**.

\*\*Confidential messages (i.e., appointment reminders)  May /  May **not** be left on answering machine or voicemail.

Please print the phone number where you want to receive calls about your appointments:

\_\_\_\_\_

I am fully aware that a cell phone is not a secure and private line.

**CONSENT TO TREAT**  
*and*  
**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT**

I, the undersigned, voluntarily give consent to my West Coast Musculoskeletal Institute medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. Also, I have received/reviewed a copy of the West Coast Musculoskeletal Institute's Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ Signature of Patient/Legal Representative	_____ Date
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_____ Please <i>print</i> Patient Name	_____ Date of Birth
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_____ Legal Representative	_____ Relationship to Patient
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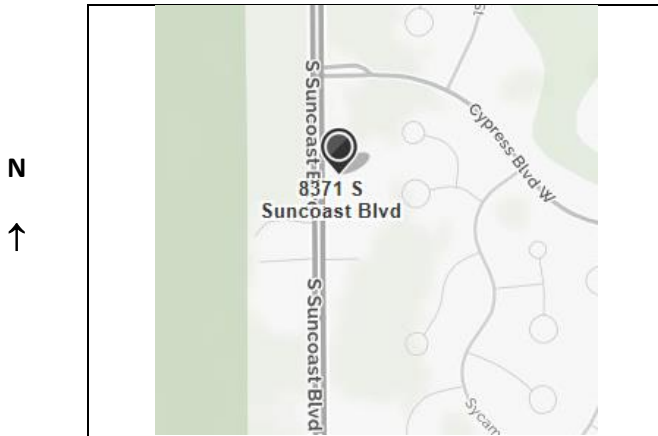
**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement for the Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

## Office Locations

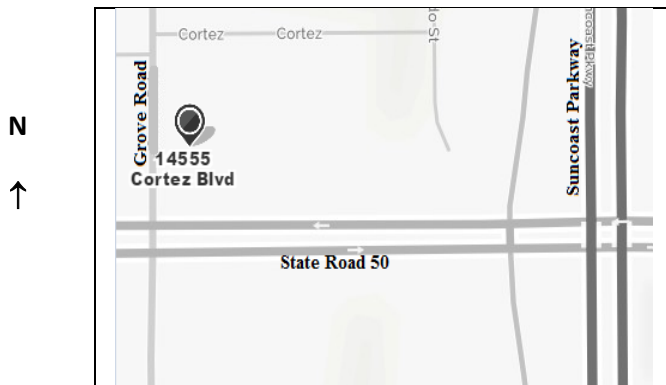
### Citrus County



8371 South Suncoast Blvd.  
Homosassa, FL 34446

*South of Cypress Blvd at Sugar Mills Woods Entrance*

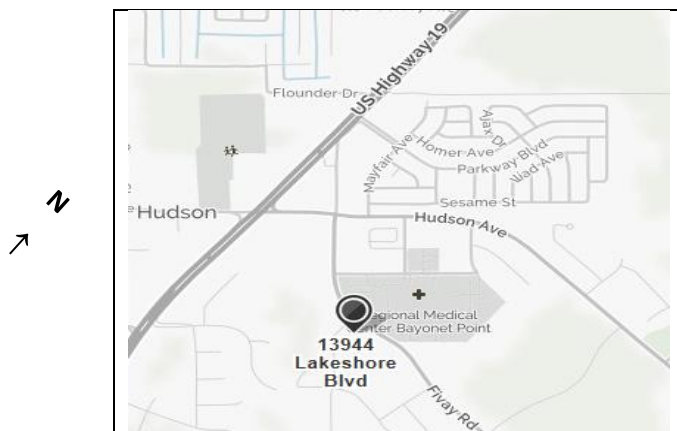
### Hernando County



1455 Cortez Blvd.  
Brooksville, FL 34613

*On the corner of Cortez Blvd and Grove Rd.*

### Pasco County



13944 Lakeshore Blvd, Suite B  
Hudson, FL 34667

*Take Hudson Avenue to Fivay Road.  
The office is across the street from Bayonet Point Hospital.*

**Please Enter through Suite A.**