CEDAR VALLEY MEDICAL SPECIALISTS, PC
JEFFREY A CLARK, DO

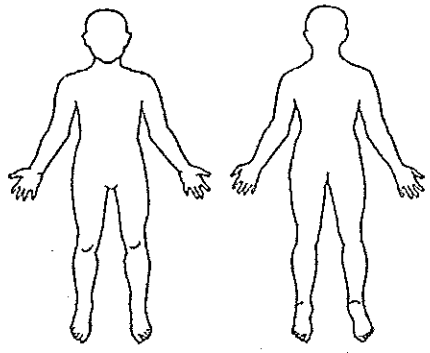
Full Legal Name_____DOB_____Age_____Today's Date_____

Height _____ Weight_____BMI_____
Family Doctor _____
Reason For Visit _____
Describe What Happened _____

Occupation_____
Referring Doctor _____
When Did it Start _____

Accident Related () Yes () No If yes: Work related () Car Accident () Athletic Injury
Please indicate LOCATION of pain on these figures using the following marks:
= = = = Aching
^^^^ Stabbing
**** Burning
xxxx Itching
\\\\ Radiating

Front Back



Please circle the number that best describes the pain level
0- No pain 1-3 Comfortable to mild pain, 4-6 Moderate pain, 7-9 Severe Pain, 10 Worst possible pain
0 1 2 3 4 5 6 7 8 9 10

QUALIFY: What does the pain feel like?
____ Dull ____Achy ___Throb ___Sharp _____Stabbing

____Tingly ____Numb ____Burning _____ Other _____

RADIATING Does the pain travel away from the site of injury/illness ( ) Yes ( ) No

If yes, where? _____

DURATION: How long does the pain or problem last?
____Seconds _____Minutes _____An Hour _____Several Hours _____All Day

TIMING: How often does the pain or problem occur?
_____Monthly _____Weekly _____Daily _____Hourly _____Constant
When do you have the MOST PAIN?
_____Morning ____Evening _____Day _____Night _____Constant

CONTEXT: Is your pain worse with
_____Sitting ____Standing _____Walking _____Lifting ____Twisting
_____Stairs ____Squatting _____Deep Knee Bends

REVIEW OF SYMPTOMS: Signs and/or symptoms you may be experiencing or have experienced recently:
General Health ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Patient Signature _____Date: _____

Completed By (If different from above: _____Date: _____

Cedar Valley Medical SPECIALISTS, P.C.
We specialize in you.℠

JEFFREY A CLARK, DO
BOARD CERTIFIED ORTHOPEDIC SURGEON
CVMS, P.C.
2351 HUDSON ROAD SUITE 001
CEDAR FALLS, IOWA 50614-0065

PATIENT NAME: _____

BODY PART: _____

HOW DID THE PAIN START? _____

_____

WHEN DID THE ACCIDENT/INJURY/CHRONIC PAIN BEGIN?

_____ ____ _____
MONTH DAY YEAR

PLEASE CHECK WHETHER THIS WAS AN:

INJURY ACCIDENT CHRONIC PAIN

WHERE DID THE ACCIDENT/INJURY/OCCUR:_____

_____

***IS THERE ANY LITIGATION PENDING OR ANY LEGAL ASPECTS OF THE INJURY:

_____YES _____NO

IF ANSWERED YES, AGAINST WHOM?

_____

_____

SIGNATURE: _____

TODAY'S DATE: _____

Name: _____ Date of Birth: ___/___/_____ Date:____/_____/____

REVIEW OF SYSTEMS:

YES	NO		YES	NO		YES	NO	
( )	( )	Weight loss	( )	( )	Fever	( )	( )	Double vision
( )	( )	Blurring vision	( )	( )	Hearing loss	( )	( )	Sinusitis
( )	( )	Difficulty swallowing	( )	( )	Dentures	( )	( )	Heart Disease
( )	( )	High blood pressure	( )	( )	Shortness of breath	( )	( )	Difficulty breathing
( )	( )	Heartburn	( )	( )	Nausea/Vomiting	( )	( )	Frequent thirst
( )	( )	Bronchitis	( )	( )	Ulcers/Constipation	( )	( )	Diarrhea
( )	( )	Frequent Urination	( )	( )	Bladder Infections	( )	( )	Blood in urine
( )	( )	Back pain	( )	( )	Gout	( )	( )	Breast Lump/Pain
( )	( )	Arthritis	( )	( )	Epilepsy	( )	( )	Skin Disease
( )	( )	Nervousness	( )	( )	Headaches	( )	( )	Thyroid Problems
( )	( )	Anxiety	( )	( )	Diabetes	( )	( )	Pulmonary Embolus
( )	( )	Anemia/Blood Disease	( )	( )	Hay Fever	( )	( )	Osteoporosis
( )	( )	Blood in Stool	( )	( )	Frequent thirst	( )	( )	Loss of Appetite
( )	( )	Chest Pain	( )	( )	Vision Loss	( )	( )	Hoarseness
( )	( )	Chronic Cough	( )	( )	Painful urination	( )	( )	Kidney Problems
( )	( )	Frequent Rashes	( )	( )	Skin Ulcers	( )	( )	Psoriasis
( )	( )	Dizziness	( )	( )	Seizures	( )	( )	Sleep Disorder
( )	( )	Depression	( )	( )	Drug/Alcohol Problem	( )	( )	HIV/AIDS
( )	( )	Hemophillia	( )	( )	Easy Bleeding			

CURRENT MEDICATIONS:

MEDICATIONS	DOSE	PRESCRIBING PHYSICIAN
1.		
2.		
3.		
4.		
5.		

ALLERGIES:

YES	NO	
( )	( )	PENCILLIN
( )	( )	SULFA
( )	( )	LOCAL ANESTHETIC
( )	( )	CODEINE
( )	( )	IVP DYE
( )	( )	OTHER/SPECIFY _____

PAST MEDICAL, FAMILY, & SOCIAL HISTORY

PAST MEDICAL HISTORY

PREVIOUS SURGERY

YES	NO	
( )	( )	BACK
( )	( )	TONSILS
( )	( )	APPENDIX
( )	( )	GALLBLADDER
( )	( )	HERNIA
( )	( )	BREAST
( )	( )	HYSTERECTOMY
( )	( )	TUBAL LIGATION
( )	( )	D&C
( )	( )	BYPASS SURGERY
( )	( )	OTHER

MEDICAL CONDITIONS

YES	NO	
( )	( )	ASTHMA
( )	( )	HEPATITIS
( )	( )	LIVER DISEASE
( )	( )	HIGH BLOOD PRESSURE
( )	( )	COPD
( )	( )	HEART ATTACK
( )	( )	ASPIRIN SENSITIVITY
( )	( )	STOMACH ULCERS
( )	( )	BLEEDING ULCERS
( )	( )	STOMACHE WHEN TAKING NSAIDS
		Which NSAIDS? _____
( )	( )	BLOOD CLOTS

FAMILY HISTORY

YES	NO	Yes	No
( )	( ) Lung Disease	( )	( ) Stroke
( )	( ) Diabetes	( )	( ) Tuberculosis
( )	( ) Cancer	( )	( ) Kidney Disease
( )	( ) Epilespy	( )	( ) DVT/PE
( )	( ) Heart Disease	( )	( ) Sickle Cell Anemia
( )	( ) Rheumatoid Arthritis		

SOCIAL HISTORY

Current Occupation_____

Important Hobbies_____

() Married () Single () Divorced () Widowed

Smoker? () Yes () No Packs per Day_____

Alcohol? () Yes () No () Socially () Daily

Caffeine? () Yes () No If yes, how much? _____

Are you on disabilities? () Yes () No

If yes, why? _____

PREVIOUS SURGERIES

	TYPE OF SURGERY	WHEN	WHERE	DOCTOR
1.				
2.				
3.				

PERTINENT ORTHOPEDIC SURGERIES

	TYPE OF SURGERY	WHEN	WHERE	DOCTOR
1.				
2.				
3.				

Patient Signature: _____Date: _____/_____/_____

Provider Signature: _____Date:_____/_____/_____

Cedar Valley Medical Specialists, P.C.

REGISTRATION FORM

(PLEASE PRINT)

Today's Date: _____

Your Pharmacy: _____

Address: _____

Patient Information (☐ VALIDATED ID ☐ PHOTO ID REFUSED ☐ NO PHOTO ID AVAILABLE)

Last name:	First:	MI:	Sex: ☐ M ☐ F
Nickname:	Birth date:	Age:	Soc. Sec. #:

Marital status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Legally Separated
- ☐ Widowed

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Bosnian
- ☐ Other _____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino
- ☐ Declined
- ☐ Unknown

Race: _____

01 = Black, African American
02 = Asian
03 = White
08 = American Indian, Alaska Native
09 = Native Hawaiian, Other Pacific Islander
98 = Unknown
99 = Declined

Address:	PO Box:	City:	State:	ZIP Code:
Home phone: ( )	Cell Phone: ( )	Email Address:		
Referred by:	Family Doctor:			
Emergency Contact Name:	Relationship:	Phone: ( )		

Student Information: ☐ Not a Student ☐ Yes if yes, ☐ full-time ☐ part-time

College Name (If attending):

Employment Information: *(If employed fill out below)* Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐

Occupation:	Employer:	Employer phone:
Spouse's Name:	Employer:	

Who will be responsible for your account? ☐ **Self** (if self, skip to next section) ☐ **Spouse** ☐ **Father** ☐ **Mother** ☐ **Other**

Name:	Soc. Sec.#	Phone:	
Address (if different):	City:	State:	Zip Code:
Employer:	Business Phone:		

Health Insurance Information (Please give your insurance card to the receptionist.)

Primary Insurance:

Insurance Company Name:	Group #:	Policy #:
Policy Holder:	Policy Holders Date of Birth:	Policy Holders S.S.#:
Insured's Employer:	Relationship to Patient:	

Secondary Insurance:

Insurance Company Name:	Group #:	Policy #:
Policy Holder:	Policy Holders Date of Birth:	Policy Holders S.S.#:
Insured's Employer:	Relationship to Patient:	

If Patient is under 18 years of age: *(and you have not provided the following information in the Health Insurance Section)*

Father's Name:		Mother's Name:	
Address:	Phone:	Address:	Phone:
Employer:		Employer:	

If this is a result of an accident or injury, please answer the following questions & complete accident/injury form.

Date of Accident or Injury:	Brief Description of Injury:

- I authorize you to give me reasonable and proper medical care by today's standards.
- I authorize Cedar Valley Medical Specialist's P.C. to release any medical information necessary to process my claim.
- I authorize payment of medical benefits to Cedar Valley Medical Specialist's P.C.
- I understand that I am responsible for any balance due on my account.
- I authorize that a copy of this information to be as valid as the original.

Signature: _____ Date: _____