



**LAWRENCE LI, MD**  
ORTHOPEDIC & SHOULDER CENTER

Minimum Invasion • Maximum Result

## ADULT REGISTRATION FORM

Account Number

Visit Date

Staff Initials

### Patient Information

Legal Name		Preferred Name		Sex	Age
Street Address		Date of Birth		Marital Status	
City, State, Zip Code		Email Address			
Home Phone (if applicable)	Cell Phone	Social Security Number			

### Emergency Contact Information

Emergency Contact	
Relationship to Patient	
Emergency Contact Phone	

### Employment Information

Employer/Occupation	
Employer's Local Address	
City, State, Zip Code	

### Primary Insurance Information

Name of Insurance Company	Relationship to Patient
Name of Insured	Subscriber DOB

### Secondary Insurance Information (if applicable)

Name of Insurance Company	Relationship to Patient
Name of Insured	Subscriber DOB

### Referring & Primary Care Physician Information

Physician who referred you	How did you hear about us?
Primary Care Physician	<input type="checkbox"/> Internet <input type="checkbox"/> Personal Referral _____
	<input type="checkbox"/> Advertisement <input type="checkbox"/> Other _____

## Patient Information

Height	Weight	Are you right or left handed?
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## Medical Conditions

**PLEASE CHECK IF YOU HAVE A HISTORY OF THE FOLLOWING**

- |                                    |   |   |                                      |                               |
|------------------------------------|---|---|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Insulin Diabetes     | <input type="checkbox"/> Urinary Tract Infection            | <input type="checkbox"/> HypoThyroid | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Non-Insulin Diabetes | <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Arthritis   |                               |

Cancer (please specify) :

Do you smoke Tobacco?

- Yes     No

Do you drink alcohol regularly?

- Yes     No

Do you use recreational drugs? *(If yes, please specify below):*

- Yes  
 No

Please list any medical conditions you may have other than the ones stated above:

Please list all surgeries you have had:

## Medications *(if you have a list, please ask the front to make a copy)*

Please list all medications, including over-the counter & herbals, with dosages, schedules, and reasons for currently taking them :

Please list all allergies to MEDICATIONS & your reaction below:

Are you allergic to Latex?

- Yes     No

## Previous Treatments

**HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES FOR THE INJURY WE ARE SEEING YOU FOR TODAY?**

- |                               |                              |                                  |                                  |   |   |
|-------------------------------|------------------------------|----------------------------------|----------------------------------|---|---|
| <input type="checkbox"/> XRAY | <input type="checkbox"/> MRI | <input type="checkbox"/> EMG/NCV | <input type="checkbox"/> CT SCAN | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy |
|-------------------------------|------------------------------|----------------------------------|----------------------------------|---|---|

If yes to any, please list **when** and **where** the procedure was performed:

## Injury Details

What is bothering you?

Which body part(s) are affected? *(Please circle **left** or **right** side):*

- |                                       |   |                                      |                                      |                                     |
|---------------------------------------|---|--------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Neck         | <input type="checkbox"/> L / R Shoulder | <input type="checkbox"/> L / R Wrist | <input type="checkbox"/> L / R Knee  | <input type="checkbox"/> L / R Foot |
| <input type="checkbox"/> Back         | <input type="checkbox"/> L / R Elbow    | <input type="checkbox"/> L / R Hand  | <input type="checkbox"/> L / R Ankle | <input type="checkbox"/> L / R Hip  |
| <input type="checkbox"/> Other: _____ |   |                                      |                                      |                                     |

Was there an injury? *(If yes, please describe below):*

- Yes     No

How long have you had this injury?

Is the problem getting worse?

- Yes     No

## Pain & Symptoms

If applicable, is your pain?

- Sharp  
 Dull  
 Aching

If applicable, is your pain?

- Occasional  
 Frequent  
 Constant

If applicable, is your pain?

- Mild     Moderate  
 Slight     Severe

Min pain level:

\_\_\_\_\_

Max pain level:

\_\_\_\_\_

What makes the pain worse/better?

\_\_\_\_\_  
**Signature of Patient/Parent/Guardian:**

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**Date:**