LAWRENCE LI, MD
ORTHOPEDIC & SHOULDER CENTER
Minimum Invasion • Maximum Result

CHILD REGISTRATION FORM

Account Number	Visit Date	Staff Initials

Patient Information

Legal Name	Preferred Name	Sex	Age
Street Address	Date of Birth	Social Security Number	
City, State, Zip Code	Are parents divorced? *(If yes, please explain custody below):* ☐ Yes ☐ No Mom: ________ % Dad: ________ %		

Parent Information

Mother's Name or Legal Guardian		***Father's*** Name or Legal Guardian	
Street Address		Street Address ☐ *Check if the same as Mothers*	
City, State, Zip Code		City, State, Zip Code ☐ *Check if the same as Mothers*	
Cell Phone	Email Address	Cell Phone	Email Address
Date of Birth	Last 4 digits of SSN#	Date of Birth	Last 4 digits of SSN#
Employer	Work Phone	Employer	Work Phone

Primary Contact *(Please select which one to contact first below):*

☐ Mom ***OR*** ☐ Dad ***OR*** ☐ Legal Guardian *(If chosen, what is your relationship to the child?):* ______________________

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? ☐ Internet ☐ Personal Referral ______________ ☐ Advertisement ☐ Other ______________
Primary Care Physician	

MEDICAL HISTORY FORM

Account Number ______ Visit Date ______ Staff Initials ______

Patient Information

Height	Weight	Are you right or left handed?

Medical Conditions

PLEASE CHECK IF YOU HAVE A HISTORY OF THE FOLLOWING

- ☐ Asthma
- ☐ Insulin Diabetes
- ☐ Urinary Tract Infection
- ☐ HypoThyroid
- ☐ Gout
- ☐ Emphysema
- ☐ Non-Insulin Diabetes
- ☐ Hypertension (High Blood Pressure)
- ☐ 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?

☐ XRAY ☐ MRI ☐ EMG/NCV ☐ CT SCAN ☐ Physical Therapy ☐ Occupational Therapy

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

INJURY FORM

Account Number ______ Visit Date ______ Staff Initials ______

Injury Details

What is bothering you?

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

- ☐ Neck
- ☐ L / R Shoulder
- ☐ L / R Wrist
- ☐ L / R Knee
- ☐ L / R Foot
- ☐ Back
- ☐ L / R Elbow
- ☐ L / R Hand
- ☐ L / R Ankle
- ☐ L / R Hip
- ☐ 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?	If applicable, is your pain?	If applicable, is your pain?	Min pain level:	Max pain level:
☐ Sharp	☐ Occasional	☐ Mild ☐ Moderate		
☐ Dull	☐ Frequent	☐ Slight ☐ Severe		
☐ Aching	☐ Constant		______	______

What makes the pain worse/better?

____

Signature of Patient/Parent/Guardian:

_____/_____/_____

Date: