

## Patient Information Intake Form

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex:  Male  Female Which is your dominate hand:  Left  Right

What doctor sent you to us: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Current Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Retired:  Yes  No

Chief complaint/reason for visit: \_\_\_\_\_

Which body part is the reason for your visit today? \_\_\_\_\_ This pain is:  New  Recurrent  Chronic

Is there a history of trauma?  Yes  No Date of onset/Injury: \_\_\_\_\_

If there is a history of trauma, what type of trauma?

- Motor vehicle accident  Fall from standing height  Fall from high structure  An altercation  A direct blow  
 Caught in machinery  Athletic Injury  Other (Specify \_\_\_\_\_)  N/A

Where did the injury occur?

- At the gym  At a nursing home  At the pool  In the street  In the yard  At home  
 At the park  At school  At work  Other (Specify \_\_\_\_\_)

Quality of pain:  Aching  Cramping  Burning  Shooting  Stabbing

Severity of pain:  No Pain (0)  Mild (1-3)  Moderate (4-6)  Severe (7-10)

Frequency of pain:  Constantly  2-4 times/day  Daily  Every several days  Intermittently  Rarely

Progression of pain since onset:

- Unchanged  Resolved  Gradually improving  Rapidly improving  Gradually worsening  Rapidly worsening  Waxing and waning

Pain is aggravated by (check all that apply):  Nothing  Movement  Palpation  Use  Weight bearing

Treatments tried to help pain (check all that apply):

- Nothing  Elevation  Ice  Non-weight bearing  Rest  Tylenol®  Anti-inflammatory medications  
 Immobilization  Injections  Heat  Physical Therapy  Brace/Orthotic/Assistive device

Improvement with treatment (check one):  No relief  Mild  Moderate  Significant

Treatments tried (check all that apply):  Physical Therapy  Injection(s)  Medication

## Review of Systems (check any of the following that you are currently experiencing)

### Constitutional

- Fever
- Chills
- Sweats

### HENT

- Facial swelling
- Nosebleeds

### Eyes

- Visual disturbance

### Respiratory

- Shortness of breath
- Chest tightness

### Cardiovascular

- Chest pain
- Leg swelling

### Gastrointestinal

- Blood In stool
- Constipation
- Diarrhea

### Genitourinary

- Difficulty urinating
- Dysuria (Pain when urinating)
- Flank pain
- Blood in urine

### Musculoskeletal

- Joint pain
- Back pain
- Difficulty walking
- Joint swelling
- Muscle pain
- Neck pain

### Neurological

- Dizziness
- Headaches
- Numbness
- Limb/muscle weakness

### Hematologic

- Bruising
- Easy Bleeding

### Psychological

- Confusion
- Nervous/anxious
- Self-inflicted injury

### Skin

- Change in color
- Rash/lesions
- Open wound

## Medical History (check all that apply)

- Alcoholism
- Anxiety
- Asthma
- Cancer
- COPD/emphysema
- Depression
- Diabetes
- DVT/PE/blood clots
- Gout
- Heart disease
- Hepatitis
- HIV/AIDS
- High blood pressure
- Kidney disease
- Malignant hyperthermia
- Osteoporosis
- Peripheral vascular disease (Poor circulation)
- Stroke
- Substance abuse
- Ulcers
- No significant history

## Surgical History (check all that apply)

- Tonsils/adenoids
- Appendectomy
- Biopsy (\_\_\_\_\_)
- Brain surgery
- Breast surgery
- Heart bypass (CABG)
- Gall bladder removal
- Colon surgery
- Cosmetic surgery
- Eye surgery
- Fracture surgery
- Gastric bypass/banding
- Hernia repair
- Hip surgery
- Hysterectomy
- Knee surgery
- Kidney stones (lithotripsy)
- Ovary removal
- Prostate surgery
- Spine surgery
- Valve replacement
- Vasectomy
- None

## Family Medical History (check all that apply)

Relationship	Living/Deceased	COPD	Heart disease	Hepatitis	Diabetes	Ulcers	Gout	HIV	Depression	Anxiety disorder	Kidney disease	Fibromyalgia	Osteoporosis	Peripheral vascular	Deep vein thrombosis	Stroke	Drug abuse	Alcohol abuse
		Mother																
Father																		
Sister																		
Brother																		

## Social History

### Marital status

- Married
- Widowed
- Single
- Divorced

Do you drink alcohol  Yes  No

Glasses of wine per week \_\_\_\_\_

Cans of beer per week \_\_\_\_\_

Shots of liquor per week \_\_\_\_\_

### Smoking status

- Current smoker
- Former smoker
- Never smoked

\_\_\_\_\_ Packs per day for \_\_\_\_\_ years

**Current Medications** List medication, dose & frequency. For example: Aspirin, 325mg, twice a day

Medication	Dose	Frequency

**Medical Allergies** List all medical allergies and reactions they cause.

Medical Allergy	Reaction

Patient /Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_