

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

Have you had any past surgeries related to the body part listed above? Yes No

Have you had any of the following diagnostic tests in relation to today's reason for visit?

MRI CT Ultrasound EMG Indium Scan Other: _____

Is today's visit due to an injury? Yes No Date of onset/Injury: _____

If there is an injury, what type of injury?

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 Boot or Cast 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
- Other: _____

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

Are you pregnant? Yes No

