

Patient Intake Form

Name: _____

Date of Birth: _____ **Age:** _____

Today's Date: _____ **Ht:** _____

Marital Status: _____ **Wt:** _____

Occupation: _____

Primary Care Physician (Name & Address):

Did a doctor request that you consult with our office for this problem? Yes No

If yes, please list doctor requesting consultation

What is injured? *Please check all that apply*

- Shoulder Elbow Wrist Hand
 Hip Knee Ankle Foot
 Neck Back Other _____

Which side? Right Left Both

Dominant Arm? Right Left

Problem(s): *Please check all that apply*

- Pain
 Weakness
 Instability/giving way/dislocation
 Stiffness
 Swelling
 Other

How did you injure yourself?

- No injury – just started hurting
 Sports – which sport?
 Motor Vehicle Accident
 Work/Job
Is there a worker's comp claim? Yes No

Date of injury: _____

Please describe the injury briefly: _____

How long have you had symptoms?

_____ Days _____ Mos _____ Yrs

What previous treatments have you had?

- Medications Physical Therapy Injections

Please describe: _____

Have you had any previous surgery for this problem?

Please list type and dates: _____

How severe is the pain? (0 = none; 10 = severe)

At rest? 1 2 3 4 5 6 7 8 9 10

At its worst? 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? Yes No

Does your pain wake you from sleep? Yes No

Are you currently working? Yes No Ret

If yes, at full capacity? Yes No

What makes your problem better? _____

What makes it worse? _____

What are you current limitations? _____

Have you had imaging studies for the body part being evaluated?

X-rays Yes No Date: _____

CT Scan Yes No Date: _____

MRI Yes No Date: _____

Other Yes No Date: _____

Are you interested in Surgery to correct your problem?

Please check one: Yes No Unsure

Medical History:

Do/did you have any heart problems? Yes No

Do/did you have ulcers/gastritis? Yes No

Do/did you have diabetes? Yes No

Do/did you have liver problems/hepatitis? Yes No

Do/did you have kidney disease? Yes No

Do/did you have cancer? Yes No

Do/did you smoke or chew tobacco? Yes No

Do/did you drink alcohol? Yes No

Other? _____

Please list all medications you are currently taking:

Allergies to Latex? Yes No

Allergies to Medication? Yes No

If yes, please list: _____

Practitioner's Initials/Date: _____



Patient Intake Form

FAMILY HISTORY: Cancer Heart Disease Diabetes Alzheimer's Stroke Seizures/Epilepsy
 Blood Clots Osteoporosis Sudden Death Death before age 50 Rheumatoid Arthritis

Please Describe: _____

REVIEW OF SYSTEMS:

1. **Constitutional General** None Recent weight changes Chills Fever Weakness/Fatigue
 Other _____

2. **Eyes** None Vision Change Glass/Contacts Cataracts Glaucoma
 Other _____

3. **Ears, Nose Throat** None Loss of hearing Ear ache or infection Ringing in ear Hoarseness
 Other _____

4. **Cardiovascular** None Chest Pain Swelling in legs Shortness of breath Palpitations Pacemaker
 Other _____

5. **Respiratory** None Shortness of Breath Wheezing/Asthma Frequent Cough
 Other _____

6. **Gastrointestinal** None Heartburn Acid Reflux Nausea or Vomiting Abdominal Pain
 Other _____

7. **Musculoskeletal** None Arthritis/joint stiffness Muscle Aches Swelling of joints
 Other _____

8. **Skin** None Rash Ulcers Abnormal Scars Sores Psoriasis
 Other _____

9. **Neurologic** None Headaches Fainting/blackouts Dizziness
 Numbness/tingling/loss of sensation
 Other _____

10. **Psychiatric** None Depression Nervousness Anxiety Mood Swing
 Other _____

11. **Endocrine** None Excessive thirst or hunger Hot/cold intolerance Hot Flashes
 Other _____

12. **Hematologic** None Easy Bruising Easy bleeding Anemia
 Other _____

Please Sign Below:

Name: _____

Date: _____

Signature: _____

**IF THIS INJURY IS RELATED TO A MOTOR VEHICLE ACCIDENT OR WORKER'S COMPENSATION, PLEASE
FILL IN THE INFORMATION REQUESTED BELOW.**

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CLAIM NUMBER: _____ DATE OF ACCIDENT: _____

ADJUSTER'S NAME: _____ TELEPHONE: _____

Practitioner's Initials/Date: _____