

Robert J. D'Agostini, Jr., M.D.  
Stephen A. Hunt, M.D.  
New Patient Intake Form

Name: \_\_\_\_\_

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

Today's Date: \_\_\_\_\_ Ht: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Wt: \_\_\_\_\_

Occupation: \_\_\_\_\_

Primary Care Physician (Name & Address):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who referred you to us?  
\_\_\_\_\_  
\_\_\_\_\_

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?

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

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: \_\_\_\_\_

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**Stephen A. Hunt, M.D.**  
**New 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**     None     Recent weight changes     Chills     Fever     Weakness/Fatigue  
   **General**             Other \_\_\_\_\_

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

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

4. **Cardiovascular**     None     Chest Pain     Swelling in legs     Shortness of breath     Palpitations  
                               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: \_\_\_\_\_