PATIENT INFORMATION SHEET
INTAKE FORM

BACKGROUND Today Date: ____________

Name:____ DOB:__________________

Age:________ Ht:___________ Wt:_______________ □ Right-Handed □ Left-Handed

Have you had 2 or more *falls* in the past year □ Yes □ No
Or have you had 1 fall with an injury □ Yes □ No
Are you Pregnant? □ Yes □ No

- Occupation: ____________________________________
- Sports/Exercise Activities:____
- Primary Care Physician: ____
- Referring provider (if different than PCP): ____
- Physical therapist: ____
- High school/College or organization (if applicable): ____
- Pharmacy name and town/address: ____

- **REASON FOR VISIT**
- Did you have an injury? □ Yes □ No If yes, what was the date of injury?___________________
- Brief history of what is bothering you, what body part is injured, and how it happened:

____
____
____

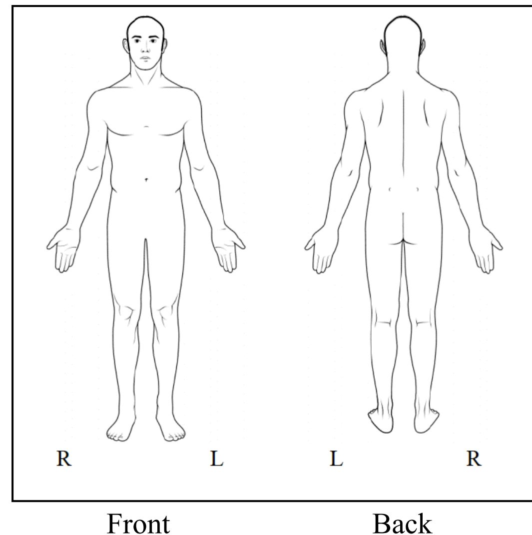
- If this is a work-related injury, is it under workers compensation? □ Yes □ No
    - Have you missed work because of this problem? □ Yes □ No
- If this injury is from an auto accident, is there a legal case? □ Yes □ No

- Please indicate whether you have had any of the following studies and write when/where the most recent was:

	Yes	No	Provide details of imaging study (body part, when/where study performed)
X-ray	□	□	________________________
CT Scan	□	□	________________________
EMG	□	□	________________________
Bone Scan	□	□	________________________
MRI	□	□	________________________
Other Imaging Study	□	□	________________________

LOCATION OF PAIN

- Mark the areas on your body where you feel symptoms. Please include all affected areas



Front Back

HOW SEVERE IS YOUR PAIN?

- On a scale of 0-10 how bad is your pain?

Example: Pain
0 10

Pain on Average
0 10

Pain at its Worst
0 10

Pain at its Best
(lying down, resting)
0 10

0 = no pain 10 = worst pain you can imagine

- Describe your pain (check all that apply)
  - ☐ Burning ☐ Numbness ☐ Tingling ☐ Decreased sensation ☐ Dull
  - ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Aching
  - Other Symptoms: ______________________________
- When do you have pain?
  - ☐ Constant ☐ Intermittent/Occasional ☐ During/After activities ☐ At night
- What activities provoke pain? Describe:______________________________
- Does the pain limit your activity? Describe:______________________________
- Have you seen another doctor for this? ☐ Yes ☐ No
  - If yes please describe? ______________________________
  - Have you had Surgery for this before? ☐ Yes ☐ No
  - If yes please describe? ______________________________

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- Have you tried of the following treatments (check all that apply):

  ☐ Physical therapy

  Location ____

  Dates ____

- Of the following list of treatment, please indicate which you have tried and if they helped:

	Treatment	Which type	Helpful	No help
☐	Anti-inflammatory Medications	☐ Ibuprofen	☐	☐
		☐ Advil	☐	☐
		☐ Naproxen	☐	☐
		☐ Celebrex	☐	☐
		☐ Other:	☐	☐
☐	Muscle Relaxants		☐	☐
☐	Narcotic Pain medications	☐ Tramadol	☐	☐
		☐ Oxycodone/Hydrocodone	☐	☐
☐	Cortisone Injection	☐ Date(s):	☐	☐
	☐ Ultrasound Guided?	☐ Date(s):	☐	☐
☐	Physical Therapy		☐	☐
☐	Chiropractor	☐ Date(s):	☐	☐
☐	Ice		☐	☐
☐	Hot Packs			
☐	Trigger Point Injection	☐ Date(s):	☐	☐
☐	Acupuncture	☐ Date(s):	☐	☐
☐	Shock wave Therapy	☐ Date(s):	☐	☐
☐	PRP/Orthobiologic Injection	☐ Date(s):	☐	☐
☐	Other:		☐	☐

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GENERAL MEDICAL HISTORY

ALLERGIES

____

____

____

MEDICATIONS (Please list all prescribed and over-the-counter medications, vitamins, and supplements)

____

____

____

PAST MEDICAL HISTORY ◻ **NO MEDICAL PROBLEMS**

Please choose all current and past medical conditions:

◻ Heart attack
◻ High blood pressure
◻ Heart failure
◻ Abnormal heart rhythm
◻ Stroke
◻ Lung disease A
◻ sthma/Bronchitis
◻ Emphysema/COPD
◻ OTHER: ____

◻ Diabetes
◻ Thyroid disease
◻ Irritable bowel
◻ Stomach Ulcers
◻ Rhematoid Arthritis
◻ Osteoarthritis
◻ Seizures
◻ Cancer, Type__________________________________

◻ Liver disease
◻ Kidney failure
◻ Bleeding disorders
◻ Anemia
◻ Blood clots in legs/lungs
◻ Osteoporosis
◻ HIV/Hepatitis/Tuberculosis

◻ Endometriosis
◻ Ovarian Cyst
◻ Kidney stones
◻ Anxiety
◻ Depression
Anorexia/bulimia
◻ Bipolar/Schizophrenia

Are you under a doctor's care for any other medical condition? ◻Yes ◻No

If **yes**, please explain:____

PAST SURGERIES (Please list any surgery and ***month/year*** of surgery)

◻ DATE:___________ ◻ PROCEDURE:____

◻ DATE:___________ ◻ PROCEDURE:____

◻ DATE:___________ ◻ PROCEDURE:____

◻ DATE:___________ ◻ PROCEDURE:____

◻ DATE:___________ ◻ PROCEDURE:____

FAMILY HISTORY (Please indicate conditions that run in your ***close family (mom/dad/sibling/grandparents)***. If yes, please indicate relationship)

Condition	Family Member	Condition	Family Member
◻ Heart disease/High blood pressure	______________	◻ Gout	______________
◻ Diabetes	______________	◻ Cancer, Type?	______________
◻ Bleeding disorder	______________	◻ Other	______________

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SOCIAL HISTORY

- Do you smoke? □ Yes □ No □ Former (Quit____________) If yes, how many packs per day? __________
- Do you drink alcohol? □ Yes □ No If yes, how many drinks per week?_________

REVIEW OF SYSTEMS (Have you experienced any of the following *recently*)

General
□ Changes in appetite
□ Fevers □ Fatigue □ Chills
□ Lightheadedness
□ Night sweats
□ Unexplained weight gain
□ Unexplained weight loss

Allergy/Immunology
□ Hives □ itching □ rash
□ Sneezing □ Wheezing

Eyes/Opthalmologic
□ Dry eyes □ Eye pain
□ Flashes of light □ Floaters
□ Loss of vision

Ear, Nose, Throat
□ Difficulty swallowing
□ Dry mouth □ Hoarseness
□ Ringing in Ears
□ Decreased hearing
□ Nosebleeds

Endocrine
□ Weight loss
□ Dizziness

Respiratory
□ Cough
□ Shortness of breath at rest
□ Shortness of breath with exertion
□ Sputum production

Cardiovascular
□ Chest pain Heartburn/acid
□ Shortness of breath
□ Palpations

Gastrointestinal
□ Abdominal pain
□ Blood in stools
□ Weight loss
□ Nausea □ Vomiting
□ Diarrhea
□ Constipation
□ Rectal bleeding

Genitourinary
□ Blood in urine
□ Difficulty urinating
□ Frequent urination
□ Painful urination

Skin
□ Rash □ itching
□ Discoloration

Neurologic
□ Seizures
□ Paralysis
□ Fainting
□ Dizziness

Psychiatric
□ Depressed mood
□ Eating disorder
□ Loss of appetite
□ Mental or physical abuse
□ Suicidal thoughts

Thank you for taking the time to complete this form

Patient's Signature:____ Date: __________