BOSTON SPORTS & BIOLOGICS

For Staff Use:
BP Reading - ___/___.

PATIENT INFORMATION SHEET
INTAKE FORM

Name:_____ Today Date: _____

DOB:_____ Ht:_____ Wt:_____

□ Right-Handed □ Left-Handed

Have you had a fall in the past year □ Yes □ No
Did the fall result in an injury? □ Yes □ No
Are you Pregnant? □ Yes □ No

BACKGROUND

- Occupation: _____
- Sports/Exercise Activities: _____
- (Student Athletes) High school/College or organization: _____
- Pharmacy name and town/address: _____
- How did you hear about us?
  - Internet/Google Search
  - Friend/Former patient: _____
  - Physician (provide name) _____
  - Physical Therapist _____
  - Chiropractor:_____
  - Other: _____

REASON FOR VISIT

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

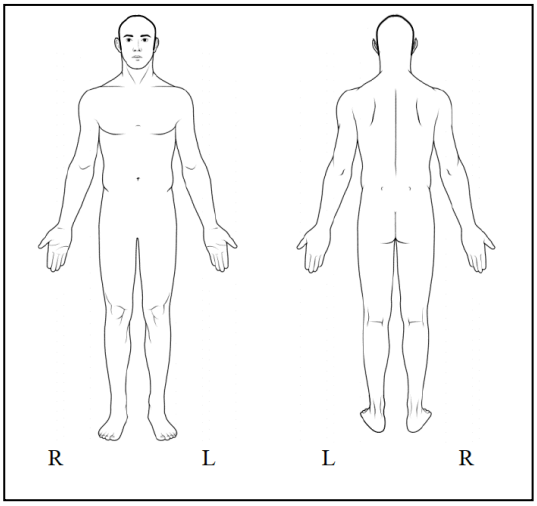
_____
_____
_____
_____

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

	Yes	No	Date	Provide details of imaging study (body part, location study performed)
X-ray	□	□		_____
CT Scan	□	□		_____
EMG	□	□		_____
Bone Scan	□	□		_____
MRI	□	□		_____
Other Study	□	□		_____

LOCATION OF PAIN

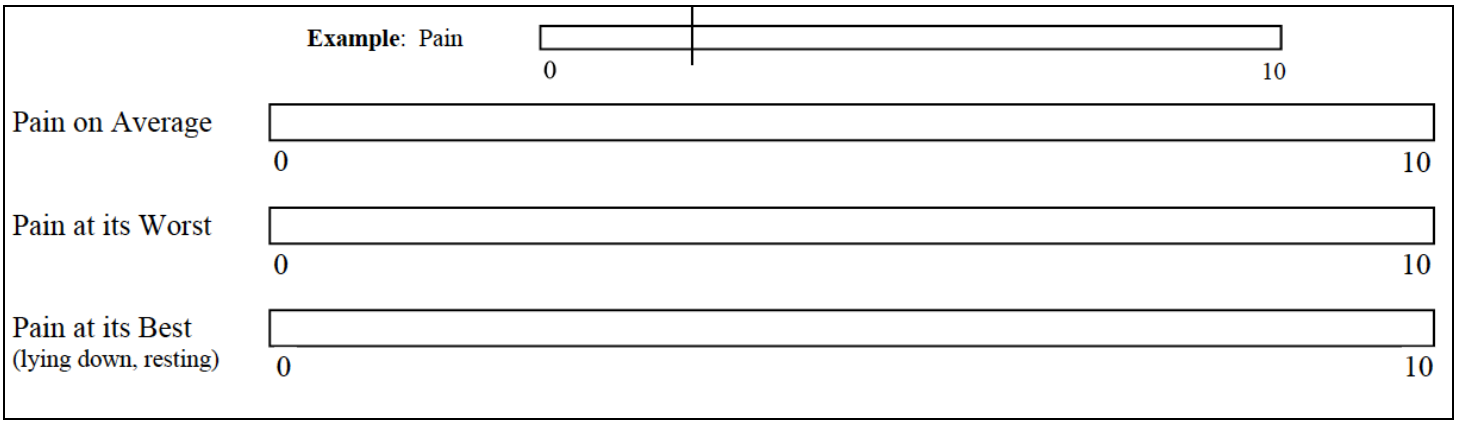
- Mark the areas on your body where you feel symptoms. Please include all affected areas



Front Back

HOW SEVERE IS YOUR PAIN?

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



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:_____

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- Have you seen another doctor for this? □ Yes □ No

  If yes, who? _____

  - Have you had Surgery for this before? □ Yes □ No

    If yes please describe? _____

- Have you tried of the following treatments (check all that apply). Please also indicate if the treatments have helped or not:

	Treatment	Which type	Helpful	No help
□	Anti-inflammatory Medications	□ Ibuprofen	□	□
		□ Advil	□	□
		□ Naproxen/Aleve	□	□
		□ Celebrex	□	□
		□ Other:	□	□
□	Tylenol/Acetaminophen		□	□
□	Muscle Relaxants		□	□
□	Narcotic Pain medications	□ Tramadol	□	□
		□ Oxycodone/Hydrocodone	□	□
□	Cortisone Injection	□ Date(s):	□	□
	□ Ultrasound Guided	□ Date(s):	□	□
□	Physical Therapy	□ Date(s):	□	□
	Location:		□	□
	Location:		□	□
□	Chiropractor	□ Date(s):	□	□
□	Ice		□	□
□	Hot Packs		□	□
□	Trigger Point Injection	□ Date(s):	□	□
□	Acupuncture	□ Date(s):	□	□
□	Shockwave Therapy	□ Date(s):	□	□
□	PRP/Orthobiologic Injection	□ Date(s):	□	□
□	Visco/HA Injections			
	□ Supartz/Hyalgan	□ Date(s):	□	□
	□ Euflexxa	□ Date(s):	□	□
	□ Gel One	□ Date(s):	□	□
	□ Durolane	□ Date(s):	□	□
	□ Other:	□ Date(s):	□	□
□	Other:		□	□

Additional Notes/Information regarding treatments you've tried: _____

_____

_____

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	□ Diabetes	□ Liver disease	□ Endometriosis
□ High blood pressure	□ Thyroid disease	□ Kidney failure	□ Ovarian Cyst
□ Heart failure	□ Irritable bowel	□ Bleeding disorders	□ Kidney stones
□ Abnormal heart rhythm	□ Stomach Ulcers	□ Anemia	□ Anxiety
□ Stroke	□ Rheumatoid Arthritis	□ Blood clots in legs/lungs	□ Depression
□ High Cholesterol	□ Osteoarthritis	□ Osteoporosis/Osteopenia	□ Anorexia/bulimia
□ Asthma/Bronchitis	□ Seizures	□ HIV/Hepatitis/Tuberculosis	□ Bipolar/Schizophrenia
□ Emphysema/COPD	□ Ehler's Danlos (ED)	□ Cancer, Type_____	
□ Parkinson's	□ OTHER: _____		

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	_____

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?_____

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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/Ophthalmologic
□ 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: _____