

Patient Intake Form

Name: _____ Email: _____ Date: _____

Height: _____ Weight: _____ Preferred Pharmacy: _____

For Staff Use Only:

Blood Pressure: _____ Pulse: _____ Age: _____ BMI: _____

What is the reason for today's visit? Please mark below:

€ Ankle	€ Hand/Fingers	€ Sacrum
€ C-Spine	€ Hip(s)	€ Shoulder
€ Coccyx	€ Knee	€ Sprain/Strain
€ Elbow/Forearm	€ L-Spine	€ Thigh
€ Follow-up	€ Lower Back	€ Toes
€ Foot	€ Lower Leg	€ Upper Arm
€ Forearm/Wrist	€ Neck	€ Upper Back
€ Fracture/Post-Op Follow-up	€ Ribs/Chest/Sternum	€ Wrist/Hand

(Circle all that apply to today's visit)

Hand Dominance: left, right, both

Location: left, right, bilateral, anterior, posterior, medial, lateral, deep, superficial

Quality: aching, burning, gnawing, stabbing, throbbing, sharp, dull, superficial, deep, occasional, frequent, constant, worsening, improving, no change

Severity: no pain, mild, moderate, severe, pain level ____/10, worst pain ____/10

Duration: date of onset: ____ days, ____ weeks, ____ months, ____ years, continuous since onset

Timing: cannot identify, acute, chronic, abrupt, gradual, morning, daytime, nighttime, recurrent, rare, occasional, intermittent episodes lasting _____

Context: cannot identify, fall, bending, lifting, twisting, sports injury, work injury, MVA, assault, overuse, a traumatic, laceration

Alleviating Factors: nothing helps, heat, ice, rest, elevation, exercise, stretching, limited weight bearing, PT/OT, chiropractic care, ESI, OTC medication, narcotics, NSAIDS, cortisone injection, viscosupplement injection, orthotics, previous surgery, brace, sling

Aggravating Factors: cannot identify, lifting, carrying, twisting, pushing/pulling, gripping, grasping, squeezing, throwing, ROM, weight bearing, exercise, previous surgery, computer use, changing clothes, getting out of bed, going from sit to stand, morning, daytime, nighttime, cold weather, damp weather

Associated Symptoms: weakness, numbness, tingling, swelling, redness, warmth, ecchymosis, catching/locking, popping/clicking, buckling, grinding, instability, radiating, drainage, fever, chills, weight loss, change in bowel/bladders habits

Previous Related Surgery: none, surgical procedure, date: _____

Prior Imaging: none, no recent studies, x-ray, MRI, CT Scan, bone scan, EMG

Previous Injections: none, did not help, helped a little, helped temporarily, helped significantly

Previous PT: none, did not help, helped a little, helped temporarily, helped significantly

Work Related: no, yes **Working:** no, regular duty, modified duty

Review of Systems

(Please circle any that apply within the last week.)

Constitutional: fever, night sweats, weight gain (____ lbs.), weight loss (____ lbs.), exercise intolerance

Eyes: dry eyes, irritation, vision change

ENMT:

Ears: difficulty hearing, ear pain

Nose: frequent nosebleeds, nose/sinus problems

Mouth/Throat: sore throat, bleeding gums, snoring, dry mouth

Cardiovascular: chest pain on exertion, arm pain on exertion, shortness of breath when walking, shortness of breath when lying down, palpitations, known heart murmur, light-headed on standing

Respiratory: cough, wheezing, shortness of breath, coughing up blood, sleep apnea

Gastrointestinal: abdominal pain, vomiting, change in appetite, black or tarry stools, frequent diarrhea, vomiting blood

Genitourinary: urinary loss of control, difficulty urinating, increased urinary frequency, hematuria, incomplete emptying

Musculoskeletal: muscle aches, muscle weakness, joint pain, back pain, swelling in the extremities

Skin: abnormal mole, jaundice, rash, itching, dry skin, growths/lesions

Neurologic: loss of consciousness, weakness, numbness, seizures, dizziness, frequent or severe headaches, restless legs

Psychiatric: depression, sleep disturbances, restless sleep, feeling unsafe in relationship, alcohol abuse

Endocrine: fatigue, increased thirst, hair loss, increased hair growth, cold intolerance

Hematologic/Lymphatic: swollen glands, easy bruising, excessive bleeding

Allergic: runny nose, sinus pressure, itching, hives, frequent sneezing

The information on the medical form(s) I am completing today is accurate and to the best of my knowledge.

Signed _____ Date: _____