New Patient Intake Form

Name _____ Date_____
DOB____/____/____Age____ Sex: ☐M ☐F
Height_____Weight_____ Handedness: ☐ R ☐L
Who referred you here? _____
Who is your PCP? _____

HISTORY OF CURRENT PROBLEM
Date your current problem began? _____
Did you ever have this problem before? ☐ Yes ☐ No
If yes, when? _____
Is your problem the result of a (n)...?
☐ Auto Accident ☐ Injury on the job
☐ Recreational Injury ☐ No known cause
☐ Other_____
Describe the original injury if known: _____
_____
Who has treated you for this problem?
Dr. _____ City: _____
Dr. _____ City: _____

TESTS you have had for this problem:
☐ X-Ray ☐ CT scan ☐ MRI ☐ EMG ☐ Other
Date(s) of test(s):_____
Where done: _____

TREATMENTS you have tried for this problem:
☐ Physical Therapy ☐ Acupuncture
☐ Chiropractor ☐ Injections/Nerve blocks
☐ Home exercises ☐ Psychological counseling
☐ TENS Unit ☐ Massage
☐ Braces ☐ Ice/heat
☐ Other_____

Have you had SURGERY for this? ☐ Yes ☐ No
Date and name of surgery: _____
_____

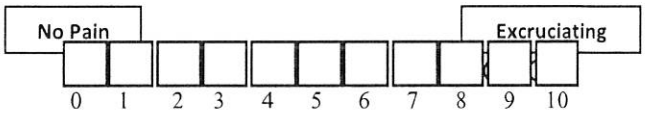
MEDICATION you have tried for this problem:

☐ Aspirin	☐ Ibuprofen (Advil/Motrin)	☐ Naproxen(Aleve)
☐ Tylenol	☐ Celebrex	☐ Diclofenac
☐ Cymbalta	☐ Prozac	☐ Trazodone
☐ Neurontin (Gabapentin)	☐ Nortriptyline (Pamelor)	☐ Amitriptyline (Elavil)
☐ Ultram	☐ Muscle Relaxers (Flexeril/Skelaxin/Soma)	☐ Lyrica

Narcotic Name(s) _____
Other meds tried: _____

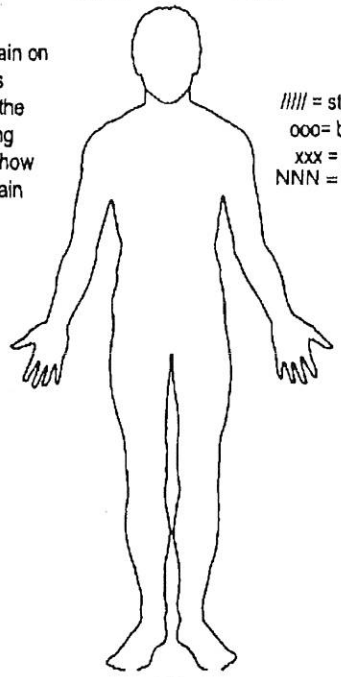
CURRENT PROBLEM:
How would you describe you problem?
☐ Constant ☐ Occasional but goes away
☐ Frequent but goes away ☐ Rare
Is your problem worse in the...
☐ Morning ☐ Evening ☐ Nighttime
What makes your problem worse?
☐ sitting ☐ standing ☐ walking
☐ other_____
_____
What makes your problem better?
☐ sitting ☐ standing ☐ walking
☐ other_____

AVERAGE PAIN INTENSITY: Fill in bubble below:



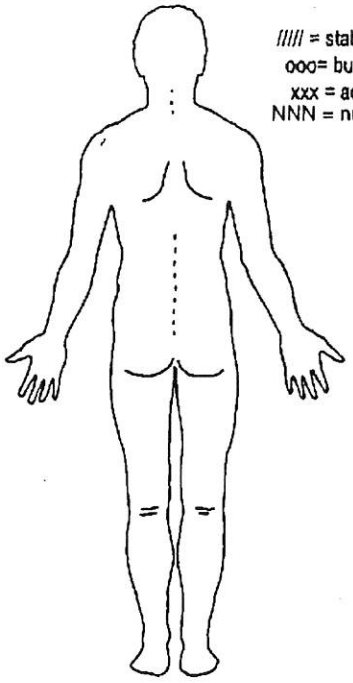
Right Left

Front
Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



//// = stabbing pain
ooo= burning pain
xxx = aching pain
NNN = numbness

Back



//// = stabbing pain
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xxx = aching pain
NNN = numbness

Left Right

Reviewed by:_____On Date: _____

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Do you have...

Fevers or chills (unexplained)	☐ Yes	☐ No
Weight loss (unexplained)	☐ Yes	☐ No
Incontinence (leak urine or stool)	☐ Yes	☐ No
Numbness in arms or legs	☐ Yes	☐ No
Weakness in arms or legs	☐ Yes	☐ No
Sleep problems	☐ Yes	☐ No
Do you have an attorney for this issue?	☐ Yes	☐ No

How long can you sit? _____

How long can you stand? _____

How far can you walk? _____

What can you NOT do because of this problem?

_____

OTHER MEDICAL PROBLEMS:

Do you have or have you ever had in the past any of the following medical problems?

☐ Eye problems	☐ Polio
☐ Anemia/bleeding problems	☐ Psoriasis
☐ AIDS/HIV	☐ Cancer
☐ High blood pressure	☐ Stroke
☐ High cholesterol	☐ Seizures
☐ Lung problems	☐ Migraines
☐ Heart disease	☐ Nerve problems
☐ Aspirin sensitivity	☐ Depression
☐ Ulcers	☐ Bipolar Disorder
☐ Hepatitis	☐ Osteoporosis
☐ Kidney disease	☐ Arthritis
☐ Diabetes	☐ Rheumatic fever
☐ Thyroid problems	Other:_____

Are you currently experiencing any of the following conditions?

☐ Difficulty swallowing	☐ Diarrhea
☐ Leg swelling	☐ Excessive urination or thirst
☐ Cough	☐ Easy bruising/bleeding
☐ Shortness of breath	☐ Rash
☐ Eye pain	☐ Joint swelling
☐ Chest pain	☐ Immunocompromised
☐ Palpitations	☐ Balance problems
☐ Constipation	☐ Feeling "down"

ANY PAST: Name type and date (month/yr), if known.

SURGERIES: _____

_____

CAR ACCIDENTS: _____

WORK INJURIES: _____

SOCIAL HISTORY: Do you currently ...

Smoke?	☐ Yes, How much? _____	☐ No
Drink alcohol?	☐ Yes, How much? _____	☐ No
Drink caffeine:	☐ Yes, How much? _____	☐ No
Use recreational drugs:	☐ Yes, What kind? _____	☐ No

Marital status: ☐ S ☐ M ☐ D ☐ W ☐ SO

Do you have any children: ☐ Yes - Ages: _____ ☐ No

Who lives with you? _____

List your hobbies? _____

What do you do for exercise, and how often do you exercise?

_____

Highest level of education:

_____

WORK HISTORY:

Which of the following best describes you currently?

☐ Currently working:

Occupation: _____

Employer: _____

How long working there? _____

Any current work restrictions? _____

Past Jobs: _____

☐ Not working because of this problem:

Date last worked? _____

How long working there until your injury? _____

☐ Not working due to another health problem:

Describe_____

☐ Unemployed ☐ Student ☐ Homemaker

☐ Retired: When_____ Occupation_____

AVERAGE DAILY STRESS LEVEL:

☐ None ☐ Mild ☐ Moderate ☐ Extreme

FAMILY HISTORY:

Have any of your parents (or close relatives) had...

☐ Neck or back problems

☐ Other muscle or bone or nerve problems

☐ Bleeding problems

☐ Cancer – Describe: _____

☐ Disability from work

☐ Diabetes

Other_____

MEDICATION ALLERGIES: Attach additional sheets if necessary.

DRUG	REACTION

CURRENT MEDICATIONS, vitamins, herbs

List every thing you take daily or as needed.

Attach additional sheets if necessary.

NAME	DOSE	FREQUENCY

PHARMACY (Name and Phone):

_____

_____

List any other concerns you have: _____

_____

What do you hope we can accomplish in today's visit? _____

_____

_____

Reviewed by: _____ On Date: _____