PATIENT INTAKE FORM

NAME_____ **DOB**_____

APPOINTMENT DATE_____

1) Major Symptom(s): (Example: headaches, back pain, neck pain, extremity pain etc.):

_____
_____
_____
_____

2) History: (How and when did your problem begin?)

_____
_____
_____
_____
_____

3) Please indicate any treatments you have had so far: (Check all that apply)

____None ____Injections ____Physical Therapy ____Chiropractic ____ Massage ____ Acupuncture

____Medications ____Surgery

a) Time frame of treatment for which you checked. *For medications, list in question # 4*

_____
_____
_____
_____
_____
_____
_____

4) Please list all medications previously taken for your pain

_____
_____
_____
_____

5) Please list all current medications, including dosage

_____
_____
_____
_____
_____
_____
_____
_____

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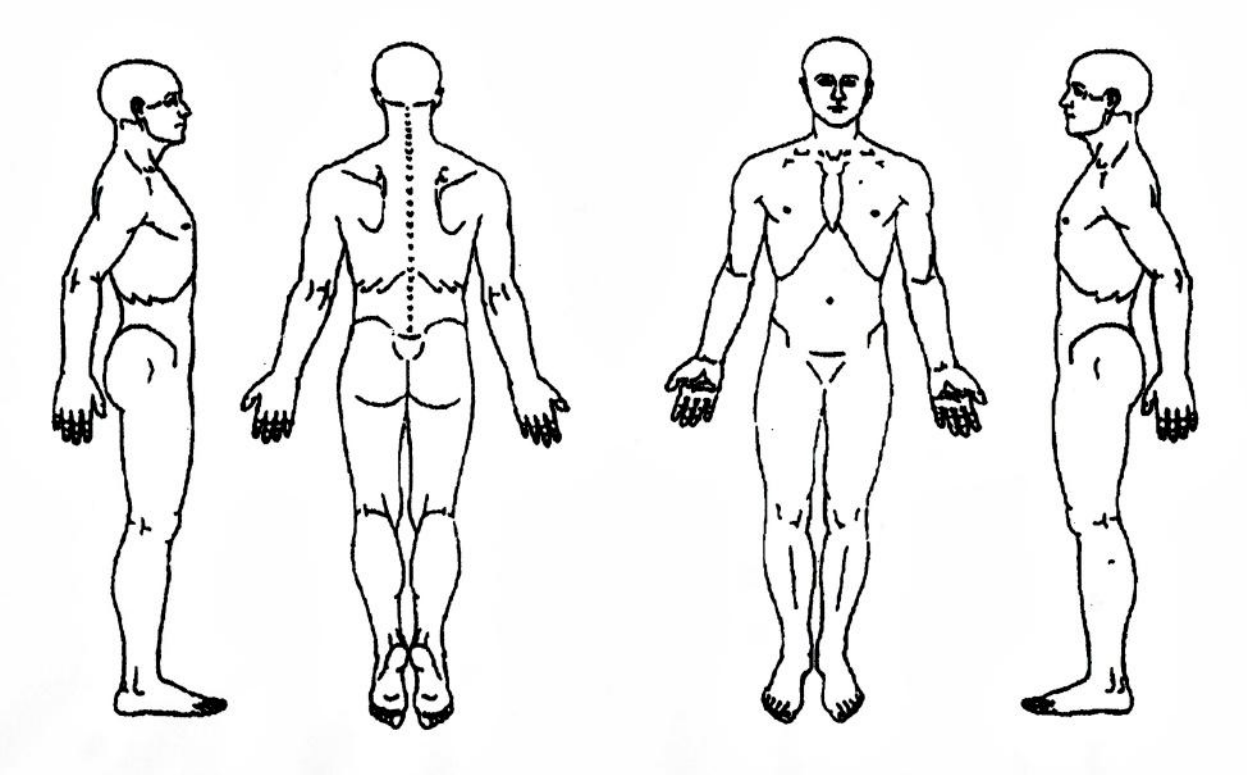
6) Please categorize your pain: (circle one) mild moderate severe

My pain is: (Please circle all that apply) constant intermittent deep superficial pressure throbbing aching burning shooting electrical numbing

7) Please mark the areas where you have pain



Modifying factors: What makes your pain better or worse? (Please check all that apply)

____Better with activity ____Worse with activity ____Better with rest ____Worse with rest

____Better with sleep ____Worse with sleep ____Better with medication ____Nothing
____Changing positions helps (describe): _____

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8) Past Medical History (Please check all that apply): ____NEGATIVE

____arthritis
____coronary disease
____asthma
____high blood pressure
____hepatitis
____colitis
____neuropathy
____excessive bleeding
____thyroid disease
____fibromyalgia
____heart attack
____COPD
____GERD
____diabetes
____anemia
____pulmonary embolus
____osteoporosis
____ stroke
____gout
____arrhythmia
____atrial fibrillation
____ulcers
____DVT (blood clots)
____hearing loss
____cancer (please be specific)_____

9) Past Surgical History (*Please list all prior surgeries and approximate dates)* _____None

_____
_____
_____
_____
_____

10) Have you had any problems with anesthesia? ____Yes ____No If yes, please explain:

_____
_____

11) Do you have any of the following problems? (Please check all that apply) _____NONE

____recent weight loss
____fever/chills
____sore throat
____heartburn
____nausea or vomiting
____rectal bleeding
____vomiting blood
____abdominal pain
____constipation/diarrhea
____burning or frequent urination
____chronic cough
____chest pain
____ shortness of breath
____ heart palpitations
____ leg swelling
____ body aches
____blurred vision
____hearing loss
____headache
____dizziness
____balance problems
____mood swings
____depression/anxiety

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12) Family History: Does a blood relative have any of the following? Please check all that apply.

____arthritis	____stroke	____osteoporosis	____hearing loss
____coronary disease	____heart attack	____arrhythmia	____colitis
____multiple fractures	____COPD	____thyroid disease	____cancer (please be specific)
____high blood pressure	____GERD	____hepatitis	_____
____cancer	____anemia	____diabetes	_____
____neuropathy	____asthma	____ulcers	_____
____substance abuse	____DVT (blood clots)	____anesthesia problems	_____

13) Social History

a) *Smoking History* Smoked at least 100 cigarettes in your life? ____Yes ____No

If yes: ____ Current every day smoker ____ Occasional smoker ____ Former smoker

For current smokers: Cigarettes per day _____ Years smoked_____

Do you use smokeless tobacco? ____Yes ____No

Are you at risk for secondhand smoke? ____Yes ____No

b) *Alcohol Use* ____none ____socially ____daily

If daily, how much and what do you drink? _____

c) *Recreational Drugs* ___ Yes ___ No (If yes, please be specific)

_____

d) *History of alcoholism or addiction?* ____Yes ____No If yes, please provide details:

_____
_____
_____

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14) Drug Allergies (Please check or list others): _____NONE

____Penicillin ____Keflex or Cephalosporins ____Sulfa ____IVP dye

____Aspirin ____ Local anesthetics (please be specific) _____

Other allergies: _____
_____
_____

15) Please list your height and weight: Height_____ Weight _____

16) Please provide the name, address, phone and fax numbers of your referring physician, primary care physician or other medical specialist who is currently treating you for this current condition.

Referring
_____
_____
_____
_____
_____

PCP
_____
_____
_____
_____
_____

Other
_____
_____
_____
_____
_____