NEW PATIENT INTAKE FORM

Demographics

Patient Name: ___________________________ Date of Consultation: _______________________
DOB: __________________ Sex: _________ Age: _________ Handedness: L *or* R *or* Both
Ht: _______ Wt: ________ Who referred you to our clinic? ________________________________
Primary Care Physician: _________________________________
Have you seen a physician, surgeon, or physical therapist for your injury/complaint? **Yes** **No**
*If **Yes**, please explain:* ____
Pharmacy Name/Address: ____
Your E-mail Address: ___________________________ Preferred Phone #: ____________________
*Can we leave a message regarding your care on your voice mail/answering machine? **Yes** **No***

Injury Information

Chief Complaint (describe the problem that brings you into the office today):

____

____

Where is the pain located (e.g., front of shoulder)**?** ______________________________________

Quality- Which of the following describe your pain (check all that apply)?

- Aching
- Burning
- Cramping
- Deep
- Disabling
- Dull
- Itching
- Pressure-like
- Sharp
- Shooting
- Stabbing
- Stiffness
- Superficial
- Tender
- Other: ___________ _________________

Severity
On a scale from 0 to 10 (0 = no pain, 10 = severe pain), please rate your pain:
Currently: ____/10
My pain is: • getting better • worsening • not changed since it started.

Onset
When did your pain begin? ____

Duration/Timing
How long does your pain last? __________________________________
My pain is • constant • intermittent (comes and goes)
My pain is worse: • in the morning • afternoon • evening • overnight • during activity
☐ after activity ☐ after I'm inactive/immobile

Radiation
Does your pain start in one location and move to another (e.g., starts in buttocks, and radiates down back of leg)? **No** **Yes** (describe): ____

Associated Symptoms

Do you experience any of the following symptoms with your pain:

- Numbness
- Tingling
- Weakness
- Sensitive to light touch
- Locking
- Catching
- Give Way/Instability
- Swelling
- Popping/Cracking
- Other: ________________
- Other: ________________
- Other: ________________

Aggravating Factors

What makes your pain worse?

- Activity
- Climbing (stairs)
- Descending (stairs)
- Changing positions
- Kneeling
- Lifting
- Lying down
- Running
- Sitting (prolonged)
- Standing (prolonged)
- Squatting
- Surgery (made it worse)
- Throwing
- Twisting/pivoting
- Walking
- Other: ________________

Alleviating Factors

What makes your pain better?

- Acupuncture
- Activity
- Changing position
- Chiropractor
- Cold pack/ice
- Hot packs
- Injections
- Lying down
- Medications (list) ______________
- Nerve blocks
- Physical therapy
- Rest
- Sitting
- Sleeping
- Standing
- Stretching
- Standing
- TENS unit
- Using a brace
- Warm shower
- Walking
- Other: ____________

Past Medical History

Please list any conditions for which you are followed by a physician:

____

____

____

Past Surgical History (include procedure, date, and surgeon/hospital)

____

____

Medications (prescription and over-the-counter. Please include name, dose, frequency)

____

____

____

Allergies to Medications, Foods, Contrast Agents (include reaction)

____

Supplements (include dietary, homeopathic, ergogenic aids)

____

____

Family History

Do you have any relatives with arthritis, rheumatologic conditions, or conditions relevant to your current symptoms? If so, please specify:

____

____

____

Social History

I am: *(check all that apply)*

- a student School/College/University: ______________ Grade/Level: _____________
- working Occupation: ____
- stay-at-home parent
- unemployed Date of last employment: ______________________________
- currently receiving Disability Benefits
- retired

Do you smoke? No Yes: ______ packs per day

Do you drink alcohol? No Yes: ______ drinks per week

Do you use illicit drugs, including marijuana? No Yes if Yes, how frequently? ______________

Sports/Athletic Activities:

____

____ Hours per week: __________

Level of Participation: Professional Collegiate High School Recreational Other: __________

Review of Systems

Recently, have you experienced any of the following:

- Fever/chills
- Nausea/vomiting
- Diarrhea/constipation/abdominal pain
- Chest pain
- Cough
- Headache/dizziness/loss of conscience
- Sore throat/Earache
- Vision changes
- Fatigue
- Weakness/Numbness
- Weight loss
- Weight gain
- Night pain
- Urinary Frequency
- Back pain
- Joint pain
- Rashes
- Shortness of breath
- Other: ______________
- Other: ______________

Are your immunizations up to date? Yes No

Did you have any imaging studies done at the time of your injury? Yes No

(If yes,) What Facility?____________________________________

Patient Signature ____ Date ____________________

Thank you for completing this questionnaire. It will help us to serve you better.

Physician Signature ______________________________________ Date ____________________