Office Use Only

Patient #_____

New Patient Intake Form

Date:_____

Patient Name:_____ DOB_____ Occupation:_____

Referring MD:_____ Diagnosis:_____

Primary Care Physician:_____ Phone:_____

Date of First MD visit for this injury:_____ Next MD appointment:_____

Reason for today's visit:_____

_____

When did you first notice symptoms of your problem?_____

Did your symptoms arise gradually? YES or NO Was there a sudden onset? YES or NO

Was there any trauma/accident that may have caused your complaints/problem? YES or NO

Please elaborate:_____

What are your present symptoms?_____

How do your present symptoms compare to your original complaint(s)?_____

_____

_____

Rate your pain on a scale of 0 (No Pain) to 10 (Excruciating pain that is disabling and requires emergency care.)

At the best moment in the past 48 hrs._____ During the night_____ At the worst moment in the past 48 hrs._____

Is your pain (please circle) CONSTANT or INTERMITTENT? Does your pain wake you at night? YES or NO

Does your pain fluctuate depending on your activities? YES or NO

Does your pain follow a pattern where it is worse in the AM or PM (circle one if yes) YES or NO

Does your pain radiate from one area to other areas? YES or NO

What activities increase your pain?_____

What activities decrease your pain?_____

Do you normally participate in any fitness activities or recreational sports? YES or NO

Please list:_____

How have you modified your activities?_____

Did your referring MD give you any instructions (i.e. for exercise, weight bearing, weaning from crutches, use of a brace?)

YES or NO Please elaborate:_____

Have you missed any work due to this injury? YES or NO

If so, what was your last day of work?_____ Date returned to work:_____ Worked part-time for period of:_____

Have you had any diagnostic tests performed? YES or NO If so, please indicate which test(s) and approximate date(s)

X-Ray:_____ MRI:_____ CT SCAN:_____ Bone Density:_____

EMG:_____ NCV:_____ OTHER(s):_____ _____

Have you had surgery for this injury? YES or NO If so, how many have you had? 1 2 3 4

Procedure(s) performed_____

Most recent surgery performed?_____ Surgeon:_____ Date:_____

Are you currently taking any medications (for this condition or anything else? YES or NO

Please list the appropriate categories:

Anti-inflammatory(s):_____ High Blood Pressure Med(s):_____

Muscle Relaxants:_____ Bone Density Drugs:_____

Pain Medications:_____ Beta Blockers:_____

Antibiotics:_____ Other(s):_____

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Have you sought care from any of the following medical providers for this injury/episode? YES or NO

Acupuncturist	_____	Massage Therapist	_____	Physical Therapist	_____
Chiropractor	_____	Neurologist	_____	Podiatrist	_____
Emergency Room	_____	Occupational Therapist	_____	Other(s)_____	
General Practitioner	_____	Orthopedist	_____	_____	

Medical History: Please check if you have had problems with the following:

____ Anemia	____ Cancer	____ Glaucoma	____ Kidney	____ Skin
____ Arthritis	____ Diabetes	____ Gynecologic	____ Liver Disease	____ Speech
____ Back Trouble	____ Drug or alcohol abuse	____ Hearing	____ Lung	____ Stomach Ulcers
____ Bleeding disorder	____ Ear, Nose, Throat, Mouth	____ Heart	____ Mental Health	____ Stroke
____ Blood Clots	____ Falls/Balance Problems	____ High Blood Pressure	____ Pancreatitis	____ Swallowing
____ Blood Transfusion	____ Fracture	____ HIV/AIDS	____ Prostate	____ Thyroid
____ Breast Cancer	____ Gallstones	____ Intestinal	____ Seizures	____ Other - specify

This intake form was reviewed by:_____ Date:_____

(Therapist Signature)