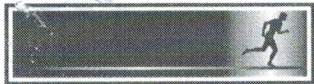
Office Use Only

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

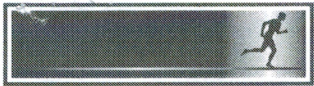
Please list the appropriate categories:

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

Muscle Relaxants:______________________ Bone Density Drugs:______________________

Pain Medications:______________________ Beta Blockers:______________________

Antibiotics:______________________ Other(s):______________________



New Patient Intake Form

Date:__________

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)