Sports Orthopedic Advanced Rehabilitation, LLC
SOAR Patient Intake Form

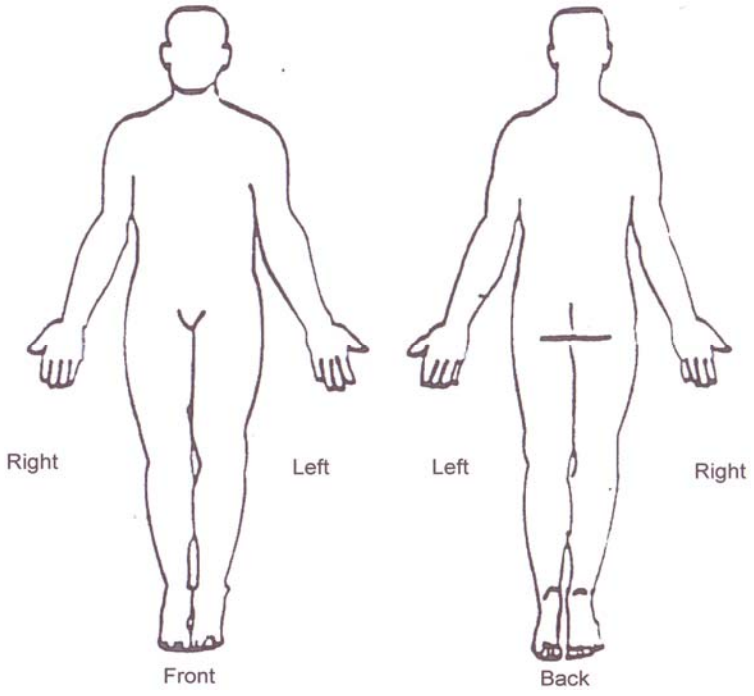
Patient Name:_____Birthdate:_____
Age: _____ Referring MD: _____
Date of Injury: _____ Is there litigation pending? **No Yes**
Is this work related? **No Yes** Is this auto accident related? **No Yes**
Have you had any previous work or auto injuries? **No Yes,when?_____**
Handedness: **Right Left Height: ___ft___in Weight: _____lbs**

1. Describe onset of injury or symptoms:_____
   _____
2. What makes it worse?_____
3. What makes it better? _____
4. On the line below, please circle your average, best and worst pain over the last week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Worst possible*

5. Where is your pain now? Use the appropriate symbols below to mark the areas on your body where you feel these sensations. Include ALL areas.

Burning X Numbness O Pins&needles = Stabbing / Ache ^



6. Have you ever had pain, discomfort or injury in this part of your body before? (please circle) **No** **Yes**, describe_____
7. Pain interferes with (circle all that apply): (relationships) (sleep) (work) (housework) (recreation activities) (driving) (sitting) (walking) (dressing) (going to bathroom)
8. Do you exercise/play sports? What and how often:_____
9. Circle previous treatments: (Physical Therapy) (Pain Clinic Eval) (Chiropractor) (Pool Therapy) (Work Eval) (Functional Capacity Eval) (Injections, please list_____)

10. What are your goals for today?_____
_____

11. List previous X-rays, MRI's, CT/CAT Scans, EMG's or other tests.

Type of study	**Date done**	**Results**

8. Other Medical Problems for which you are or have been treated:
Heart attack/heart disease High blood pressure Diabetes Stroke
Glaucoma Asthma Emphysema/COPD/Lung Disease Kidney disease
Epilepsy Migraines Depression Anemia Bleeding problems
Stomach ulcers Arthritis Osteoporosis Cancer(type_____)
Other_____

9. ALLERGIES:_____

10. Present Medications:

Medication Name	**Dosage**	**How often**	**Helpful?**

11. Please list Surgeries you've had:

Surgery	Date

12. Please circle, if you've experienced the following in the past 6 months:

Weight loss Weight gain Stomach pain Stomach ulcers
Chest pain Dizziness Shortness of breath Dry eyes or mouth
Skin rashes Fever Difficulty controlling bowel or bladder
Problems sleeping Depression Falling/tripping Joint swelling
Nausea/vomiting Bleeding problems

12.Family Medical Problems- Do parents, grandparents or siblings have:
(please circle all that apply):
Heart disease High blood pressure Diabetes Stroke Arthritis
Osteoporosis Cancer(type_____)
Other_____

14. If you work, please describe your job and hours:_____
_____

15. Education level: (Some High School) (High School Graduate) (Tech School) (Some College) (College Graduate) (Grad school, degree__)

16. Marital status: Single Married Divorced Widowed
17. Number of children:_____ Ages:_____

18. Do you smoke? No Yes, how much?_____
19. Do you drink alcohol? No Yes, how much?_____
20. Have you ever had any problems with substance misuse? No Yes, when?_____ which one's?_____

Patient Signature:_____Date:_____

THANK YOU VERY MUCH FOR COMPLETING THIS FORM