Sports Orthopedic Advanced Rehabilitation, LLC
SOAR Patient Intake Form

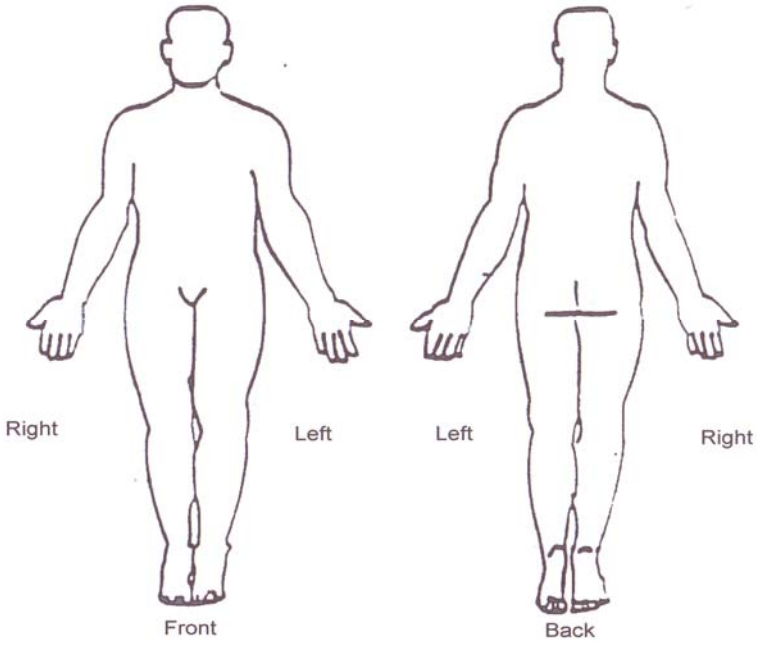
Patient Name:_____ Date:_____
Birthdate:_____ Age: _____ Referring MD: _____
Date of Injury: _____ Is there litigation pending? **No Yes**
Is this work related? **No Yes** Is this auto accident related? **No Yes**
Have you had any previous work or auto injuries? **No Yes, when?_____**
Handedness: **Right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

1. Describe onset of injury or symptoms:_____
   _____
2. What makes it worse?_____ What makes it better? _____
3. 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*

4. 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 ^



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

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

Type of study	Date done	Results

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

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

14. If you work, please describe your job and hours:_____
_____
15. Education level: High school Tech school College 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?_____

Patient Signature: _____Date: _____