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PATIENT/PROBLEM INTAKE FORM

(To be completed only if you are a new patient or an established patient being seen for a new problem)

Patient Name: ________________________ **Date:** ________________________

Age: __________ **Date of Birth:** __________ **Height:** __________ **Weight:** __________

CHIEF COMPLAINT

Reason for today's visit?	Have you been treated for this problem before? ❑ Yes ❑ No
Date of Injury/Onset of Problem:	Current problem is a result of (*Check all that apply*): ❑ MVA ❑ Work Accident ❑ Other *(please specify)*

MEDICAL HISTORY (*Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?)*

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Anemia	❑	❑	Gallbladder Problems	❑	❑	Lung Problems	❑	❑	Stroke/TIA
❑	❑	Arthritis	❑	❑	Gout	❑	❑	Phlebitis	❑	❑	Tuberculosis
❑	❑	Asthma	❑	❑	Heart Disease	❑	❑	MRSA/Staph Infection	❑	❑	Thyroid Problems
❑	❑	Birth Defects	❑	❑	Hepatitis	❑	❑	Osteoporosis	❑	❑	Ulcer
❑	❑	Bladder Problems	❑	❑	HIV/AIDS	❑	❑	Peripheral Vascular Disease	❑	❑	
❑	❑	Bleeding or Bruising	❑	❑	High Blood Pressure	❑	❑	Polio	❑	❑	
❑	❑	Cancer	❑	❑	High Cholesterol	❑	❑	Psychological problems	❑	❑	
❑	❑	Diabetes	❑	❑	Intestinal/Bowel Problems	❑	❑	Pulmonary Embolism	❑	❑	
❑	❑	DVT/Blood Clots	❑	❑	Kidney Problems	❑	❑	Rheumatic Fever	❑	❑	
❑	❑	Epilepsy	❑	❑	Liver Disease	❑	❑	Sexually Transmitted Disease	❑	❑	

Are there any other medical conditions/problems we should know about? ________________________

Are you right or left-hand dominant? ❑ **Right** ❑ **Left** **Are you or could you be pregnant?** ❑ **Yes** ❑ **No** ❑ **N/A**

MEDICATIONS *(Please list all medications you take with or without a prescription)*

Medication Name	Dosage (# per day)	Indication

ALLERGIES *(Please list any allergies or known allergic reactions to medications and/or food)*

Allergy to…	Reaction (itching, cough, hives, etc.)	Treatment

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Patient Name: ______________________________ **DOB:** ______________________________

SURGERIES AND HOSPITALIZATIONS

		Year	Physician	Complications?
❑	Joint Replacement			
❑	Arthroscopy			
❑	Carpal Tunnel			
❑	Rotator Cuff			
❑	Other hospitalizations ____________________________			

FAMILY HEALTH HISTORY *(Have your mother, father, grandparents, brothers, or sisters been treated in the past or are currently receiving treatment for any of the following conditions?)*

Yes	No		Yes	No		Yes	No		Other:
❑	❑	Alzheimers	❑	❑	Diabetes	❑	❑	Osteoporosis	____________________
❑	❑	Arthritis	❑	❑	Gout	❑	❑	Stroke	____________________
❑	❑	Cancer	❑	❑	Heart Disease	❑	❑	Sudden Death	____________________

SOCIAL HISTORY

Do you smoke or chew tobacco?	❑ Yes	❑ No	If yes: ________ packs per day, for ________ years
Do you drink alcoholic beverages?	❑ Yes	❑ No	Amount and frequency:
Do you use recreational drugs?	❑ Yes	❑ No	Type and frequency:

REVIEW OF SYSTEMS *(Please check the following symptoms you have experienced on a regular basis)*

GENERAL
- ❑ NONE
- ❑ Fever
- ❑ Weight Change
- ❑ Hormonal problems
- ❑ Other:

CARDIOVASCULAR
- ❑ NONE
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Fluid/swelling in extremities
- ❑ Other:

KIDNEY/BLADDER
- ❑ NONE
- ❑ Painful urination
- ❑ Frequent urination
- ❑ Incontinence
- ❑ Other:

EYES
- ❑ NONE
- ❑ Glasses/contacts
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Other:

RESPIRATORY
- ❑ NONE
- ❑ Shortness of breath
- ❑ Sleep apnea
- ❑ Wheezing
- ❑ Other:

EARS, NOSE, THROAT
- ❑ NONE
- ❑ Difficulty swallowing
- ❑ Ear pain
- ❑ Seasonal allergies
- ❑ Hard of hearing
- ❑ Other:

GASTROINTESTINAL
- ❑ NONE
- ❑ Heartburn
- ❑ Diarrhea/Constipation
- ❑ Abdominal pain
- ❑ Nausea/vomiting
- ❑ Other:

SKIN
- ❑ NONE
- ❑ Rashes
- ❑ Lumps
- ❑ Other:

HEMATOLOGIC/LYMPHATIC
- ❑ NONE
- ❑ Anemia
- ❑ Blood problems
- ❑ Clotting disorder
- ❑ Lymph problems
- ❑ Other:

NEUROLOGICAL
- ❑ NONE
- ❑ Headaches
- ❑ Numbness
- ❑ Tingling
- ❑ Seizures
- ❑ Weakness
- ❑ Other:

PSYCHOLOGICAL
- ❑ NONE
- ❑ Anxiety
- ❑ Depression
- ❑ Mood swings
- ❑ Other:

Patient Signature: ______________________________ **Date:** ____________________

Reviewed by: ______________________________ **Date:** ____________________