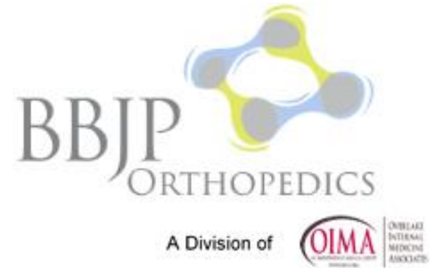
New Patient Intake Form



Please complete information below

Name: ______________________________ **DOB**________ **Age**__________ ☐ **Male** ☐ **Female**

Referring Physician____ FAX__________________
Address ____ Phone ________________

Primary Care Physician____ FAX __________________
Address ____ Phone_________________

Is this a work related problem? Yes___ No___ If yes, list your OWCP or L&I #______________________
If disabled, when did you last work? ____

Is this a Motor Vehicle Accident related problem? Yes___ No___

Do you currently reside in a skilled nursing facility? Yes ___ No ___
If so where? ____
From what dates? ____________________________________

Chief Complaint: ____ ☐ **Right** ☐ **Left** ☐ **Both**

When did this problem begin (date of injury):________________ Hand Dominance? Right☐ Left ☐

How did it happen: ____

Circle the symptoms that best describe your problem: Stiffness Pain Instability Numbness Swelling
Other________________

If you have pain, please circle the description that is most appropriate:
Sharp Throbbing Aching Burning Stabbing Heavy Dull

Circle the number corresponding to the intensity of your pain:
(0 = no pain and 10 = the worst pain imaginable) 0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing?
Better Gradually Better Rapidly Worse Gradually Worse Rapidly Staying the Same

Circle what improves your symptoms? Rest Ice Heat NSAID Splinting Massage
Other______________

Circle what worsens your symptoms? Activity Cold Pressure Other______________

What studies or treatments have you had for this problem? (**Circle** all that apply)
X-rays CT MRI Nerve study (EMG) Arthrogram Bone Scan Surgery

Social History

What is your height and weight?
Height in feet and inches _______________ Weight in pounds _________________

Do you smoke?
Yes___ No___ If yes, how much of a pack per day?____How many years have you been smoking?_____

Were you previously a smoker?
Yes___No___ If yes, when did you quit and how long did you smoke for? _______________________

Do you have any children?
Yes___ No___ If so how many children? ____

Do you drink alcohol?
Yes___ No___ If yes, how many drinks per week? ____

Do you drink caffeine?
Yes___ No___ If yes, how many drinks per week? ____

Do you following a specific diet?
Yes___ No___ If yes, which diet? __________________

Have you ever had a drug or alcohol problem? If yes, please specify
Yes___ No___

Work status?
Employed Unemployed Disability Student Retired Homemaker

Occupation_________________________________ Highest level of education__________________

Do you exercise?
Yes___ No___ If yes, how many times per week? ____ What type of exercise? ________________

Marital Status?
Single Married Divorced Separated Widowed Domestic partner

Personal Medical History

Please circle if you have a history of any of the following,

Allergies	Anxiety	Asthma	Bipolar
Bleeding Disorder	Cancer	Chronic Lung Disease	Coronary Artery Disease
Congestive Heart Failure	Depression	Diabetes	DVT/Clotting Disorder
Fibromyalgia	Heart attack	Heartburn/reflux	Hepatitis ___ (specify type)
High Blood Pressure	High cholesterol	Kidney Disorder	Liver Disorder
Neck Fusion	Psoriasis	Rheumatoid Arthritis	Sleep Apnea
Stroke	Thyroid Disorder	Other ___________	

Family History

Please circle if any of your family members have had the following,
PLEASE SPECIFY WHICH FAMILY MEMBERS (Indicate maternal or paternal when applicable)

Diabetes ________________	High Blood Pressure ___________________	Stroke __________________	Heart attack _____________	Cancer __________________
Depression ________________	Kidney/ Liver Disease ____________________	Rheumatoid __________________	Gout ______________	Bleeding Disorder __________________
Arthritis ________________	Autoimmune ____________________	DVT/Clotting Disorder __________________	Other ______________	

Surgical History

Surgeries: (Please **circle** all that applies)	Year	Other surgeries		
No previous surgeries		Procedure	Year	L or R
Appendix (appendectomy)	_____			
Gall bladder (cholescystectomy)	_____	___________________________	_____	_____
By-pass/open heart (CABG)	_____			
Hernia repair	_____	___________________________	_____	_____
Hysterectomy	_____			
Tonsils removed (tonsillectomy)	_____	___________________________	_____	_____
C-Section	_____			

Allergies

Please circle if you have any of the following allergies and specify your reaction

No Known Drug Allergies	Erythromycin _____________	Codeine _____________
Iodine _____________________	Penicillin _________________	Others:_______________
Sulfa ______________________	Latex____________________	

Current Medications: **Dose:** **Times per day:** **Reason you are taking**

1.____

2.____

3.____

4.____

5.____

6.____

7.____

***OR ATTACH LIST OF MEDICATIONS _____**

Review of Systems

	Yes	No	Comments
General (weight gain/loss, fatigue, insomnia, fever/chills)			
Eyes (glasses/contacts, cataracts, glaucoma)			
Ear/Nose/Throat (sinus trouble, hearing loss)			
Heart (chest pain, high blood pressure, coronary artery disease, irregular heartbeat)			
Lungs (shortness of breath, asthma, lung disease)			
Stomach (heartburn, nausea, diarrhea, hepatitis)			
Muscle / Bones (joint pain, muscle pain, arthritis, fractures, sprains)			
Urinary Tract (painful urinating, kidney stones, prostate)			
Skin (masses, blisters, dermatitis, eczema)			
Neurologic (seizures, numbness/tingling)			
Mental Health (anxiety, depression)			
Endocrine (frequent urination, excessive thirst, diabetes, hypothyroid)			
Hematological (bleeding/clotting problems, anemia, swollen lymph nodes)			
Allergic / Immunologic(HIV/AIDS, hay fever lupus)			