

Medical Intake Form

Patient Name: _____ **Date of Appointment:** _____

Patient Date of Birth: _____ **Height:** _____ **Weight:** _____ **lbs**

Sex: Male Female Other: _____

Preferred pharmacy: _____ **Primary Care Physician:** _____

• **Reason for Visit**

What brings you to the office today? (Please list **body part** and Right, Left, or Bilateral if applicable)

• **When did this problem begin?**

• **What event or incident is this problem related to?**

Work Accident Car Accident

Other (Please specify): _____

Do you have an Attorney for this injury? Yes No

Attorney Name: _____

• **If this injury is related to a motor vehicle accident, please fill out this box:**

Type of Impact:

Front Rear Driver's Side Passenger's Side

Were you wearing a seatbelt? Yes No

Did the airbags deploy? Yes No

• **Previous Studies**

No Previous Studies

Please check any previous studies you have had for your current problem:

Diagnostic X-rays

MRI

CT Scan

Myelogram

Discogram

EMG/NCS

Arthrogram

Other _____

If you checked any of the boxes above please specify which

facility you went to: _____ Date: _____

• **Previous Treatments**

Bracing

Physical Therapy

Chiropractic

Massage

Injections

Ice/Heat

Pain Medications/NSAIDs

No Previous Treatments

• **Check the symptoms that best describe your problem:**

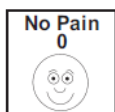
Aching Throbbing Stabbing Burning

Numbness Tingling Stiffness Swelling

Pain Instability Other: _____

• **Are you right or left hand dominant?** Right Left

• **Pain Scale - If you are having pain, please rate the intensity of your pain on a scale of 1-10.**



1

2

3

4

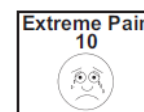
5

6

7

8

9



Doctor's Notes - Office Use Only

• Review of Systems/Medical History

Are you currently having or have you ever had problems with any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Gout/
Pseudogout | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> DVT |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> MRSA | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Lungs/Breathing | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Digestion | <input type="checkbox"/> Bowel Movement | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Balance Issues | <input type="checkbox"/> Blackout/Fainting | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cardiac Stent | |

If you checked **any** of the boxes in the above sections, please describe in detail:

• Social & Lifestyle Factors

Have you ever smoked?	Yes <input type="checkbox"/> No <input type="checkbox"/>	# Of Years? _____	# Per Day? _____	Current Smoker? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you use recreational drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	What Types / How Often? _____		
How many alcoholic beverages do you consume per week? _____	How many times a week do you exercise? _____			

• Hospitalizations & Surgeries

Have you had any previous surgeries? Yes No

If yes, did you have any complications with your previous surgery/anesthesia? Yes No

Please list below any surgeries and/or procedures you have had in the past:

Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

• Medications/Supplements (Please list all current medications/supplements below):

Are you currently taking any blood thinners? Yes No

Medication	Strength	Times per day

Medication	Strength	Times per day

• Family Medical History

Has any of your immediate family members suffered any of the following conditions? If so, please check boxes accordingly.

Condition	Father	Mother	Brother	Sister
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (HT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family History Unknown No Known Family History

If you checked any of the boxes under **Cancer**, please specify which type of cancer: _____

• Allergies

No Known Allergies

Are you allergic to any of the following?

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Adhesive Tape |
| <input type="checkbox"/> Iodine/IV Dye | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Eggs/Avian Products | <input type="checkbox"/> Other: _____ | |

List reaction: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____