PATIENT INTAKE FORM

Name:_____ Today's Date: _____

Height:_____ Weight: _____

WHAT SYMPTOMS ARE YOU CURRENTLY EXPERIENCING?

Body Part: □ Left / □ Right _____

□ Pain □ Swelling □ Decreased ROM □ Stiffness □ Weakness □ Instability □ Numbness

Place of Injury:	□ Home	□ MVA	□ School	□ Work	□ During Sports
Frequency of Pain:	□ Intermittent	□ Occasional	□ Constant	□ Rare	
Status of Pain:	□ Worsening	□ Stable	□ Fluctuating	□ Improving	
Severity of Pain:	□ Mild	□ Moderate	□ Severe		
Quality of Pain:	□ Aching	□ Deep	□ Discomfort	□ Dull	
	□ Piercing	□ Sharp	□ Stabbing	□ Throbbing	
Timing of Pain:	□ At Night	□ At Rest	□ Continuous	□ With Activity	

Please rate your pain on a scale of 1 to 10 (10 being the most painful)

BEST PAIN 1 2 3 4 5 6 7 8 9 10 **CURRENT PAIN** 1 2 3 4 5 6 7 8 9 10 **WORST PAIN** 1 2 3 4 5 6 7 8 9 10

Are your symptoms AGGRAVATED by any of the following:

□ Daily Activities	□ Ascending Stairs	□ Descending Stairs	□ Exercise	□ Movement
□ Physical Therapy	□ Sleeping	□ Sports	□ Standing	□ Walking

Are your symptoms RELIEVED by any of the following:

□ Bracing	□ Elevation	□ Exercise	□ Ice	□ Injections	□ Massage
□ NSAIDS	□ Rest	□ Physical Therapy	□ Pain Medicine		□ Heat

Please list any symptoms associated with your pain/injury:

□ Decrease Mobility	□ Difficulty Bending	□ Instability	□ Limping	□ Joint Pain
□ Locking	□ Loss of Motion	□ Pain	□ Popping	□ Stiffness

What treatments have you tried for this injury?

□ Nothing □ Exercise □ Activity Modification □ Decreased Activity □ Bracing
□ Injections (i.e. Synvisc/Hyalgan/Cortisone) (Date Started:_____)
□ Physical Therapy (Date Started:_____)
□ Chiropractic (Date Started:_____)
□ Medications_____(Date Started:_____)

**Have you had any changes to your medications since your previous visit? □ Yes / □ No
If Yes, Please list all changes:

_____

_____

PATIENT INTAKE FORM

Name:_____ Today's Date: _____

POST OPERATIVE VISITS

How are you doing? _____

Have you experienced any of the following since surgery…….

□ Fevers □ Chills □ Sweats □ Excessive Swelling
□ Numbness/Tingling □ Chest Pain □ Loss of Appetite □ Shortness of Breath
□ Drainage from Incision

Is the patient requesting a medication refill? _____

Additional Comments / Patient Concerns:

_____

_____

_____

REVIEW OF SYSTEMS

CONSTITUTIONAL
- Change in Appetite
- Chills
- Decreased Activity
- Decreased Appetite
- Fatigue
- Fever
- Increased Appetite
- Insomnia
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

HEENT
- HEAD
  - Headache
- EYES
  - Burning
  - Itching
  - Vision Loss
- EARS
  - Hearing Loss
- NOSE
  - Sinusitis
  - Sneezing

RESPIRATORY
- Asthma
- Cough
- Painful Respiration
- Wheezing
- Shortness of Breath

CARDIOVASCULAR
- Chest Pain
- Irregular Heartbeat / palpitations

VASCULAR
- Edema
- Ulcer
- Varicose Veins

GASTROINTESTINAL
- Constipation
- Diarrhea
- Nausea
- Vomiting

NEUROLOGICAL
- Headache
- Light-Headedness
- Seizures

PSYCHIATRIC
- Inappropriate Interaction
- Inconsolable
- Psychiatric / Emotional
- Anxiety

DERMATOLOGIC
- Rash
- Skin Lesion

MUSCULOSKELETAL
- Back Pain
- Bone/Joint Symptoms
- Muscle Weakness
- Calf Tenderness

HEMATOLOGIC
- Easy Bleeding
- Easy Bruising

IMMUNOLOGIC
- Seasonal Allergies