PHYSIATRY INTAKE FORM

Patient Name: _____ **DOB:**_____

Referring Physician - Name: _____

Primary Physician - Name: _____

Preferred Pharmacy - Name/Address: _____

Preferred Laboratory – Name/Address: _____

Email Address: _____

CURRENT MEDICAL INFORMATON

Height:_____ **Weight:** _____

What is the reason for your visit today? _____

How long have the above symptoms been present? _____

Work related Injury? _____ **Auto Accident Injury?** _____

Pain Scale from 1 to 10 (10 being the worst?) _____

How can the current problem be characterized?

☐ Intermittent	☐ Constant	☐ Burning
☐ Dull	☐ Sharp	☐ Stabbing
☐ Throbbing	☐ Aching	☐ Cramping
☐ Pressure	☐ Radiating	☐ Electrical

What additional symptoms are you experiencing?

☐ Chills	☐ Fever	☐ Numbness
☐ Stiffness	☐ Tingling	☐ Weakness
☐ Swelling	☐ Fatigue	☐ Headaches
☐ Limit of Motion	☐ Difficulty Walking	☐ Catching / Locking
☐ Loss of Bowel or Bladder Control	☐ Sleep Disturbance	
☐ Radiation of Pain	☐ Other	

Since the onset, what is the status of your symptoms? ☐ **Improved** ☐ **Worsening** ☐ **No Change**

Symptoms feel worse with: ☐ **Nothing makes the symptoms worse**

☐ Activity	☐ Rest	☐ Twisting/Turning
☐ Climbing stairs	☐ Sitting	☐ Walking
☐ Heat	☐ Sleeping	☐ Working
☐ Ice/Cold	☐ Sports	☐ Other

The symptoms improve with: ☐ **Nothing improves the symptoms**

☐ **Activity**	☐ **Ice/Cold**	☐ **Rest**
☐ **Heat**	☐ **Medication**	☐ **Other**

Have you had prior treatment for your current orthopedic problem?

☐ **No prior treatment** ☐ **Yes, I had prior treatment**

If Yes, please check the box for all the prior treatment that was done.

☐ **ER Visit or Urgent Care**

☐ **Primary Care Facility or other Treating Physician**
If selected, please list the name of the Physician seen _____

☐ **NSAIDS (for example, Advil or Ibuprofen)**

☐ **Pain Medications**

☐ **Muscle Relaxers**

☐ **Epidural Blocks**

☐ **Injections**

☐ **Physical Therapy**

☐ **Chiropractor**

☐ **EMG or NCS**

☐ **Surgery**
If selected, please list the who performed the surgery _____

ALLERGIES

Please list any allergies you have and the adverse reaction.

	Allergic to:	**Physical Response:**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

MEDICATIONS

1.	_____	**5.**	_____
2.	_____	**6.**	_____
3.	_____	**7.**	_____
4.	_____	**8.**	_____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

Y or N	Fever	Y or N	Night Sweats
Y or N	Eye Irritation	Y or N	Vision Changes
Y or N	Difficulty hearing	Y or N	Teeth Problems
Y or N	Mouth Breathing		
Y or N	Chest Pain	Y or N	Shortness of breath when walking
		Y or N	Shortness of breath lying down
Y or N	Shortness of breath	Y or N	Wheezing
Y or N	Sleep Apnea		
Y or N	Abdominal Pain		
Y or N	Difficulty Urinating	Y or N	Increased Frequency
Y or N	Incomplete emptying		
Y or N	Muscle Aches	Y or N	Muscle Weakness
Y or N	Joint Pain	Y or N	Back Pain
Y or N	Swelling of the extremities		
Y or N	Skin rashes	Y or N	Growths or lesions
Y or N	Seizures	Y or N	Dizziness
Y or N	Headaches	Y or N	Migraines
Y or N	Depression	Y or N	Sleep disturbance
Y or N	Fatigue	Y or N	Increased thirst
Y or N	Easy bruising	Y or N	Excessive bleeding
Y or N	Hives		

SOCIAL HISTORY

What is your smoking status? Currently Every Day / Currently Some days / Formerly Smoked / Never Smoked

How much do you smoke?

¼ pack per day?	¼ pack per week?
½ pack per day?	½ pack per week?
1 pack per day?	1 pack per week?
2 packs per day?	2 packs per day?
3 packs or more per day?	

Have smoked since what age? _____

What is your alcohol intake? None Occasional Moderate Heavy

How many years of alcohol use? _____

Do you take any illicit drugs? _____ **Are you employed?** _____

PAST MEDICAL HISTORY

Have you experienced any of the following symptoms in the PAST?

Y or N	Arthritis	Y or N	Anemia, Bleeding Disorders/Tendencies
Y or N	Blood Clots	Y or N	Breathing problems
Y or N	Cancer	Y or N	Chest pain/heart attach/arrhythmia
Y or N	Coronary Artery Disease	Y or N	Depression/Psychiatric Problems
Y or N	Diabetes	Y or N	Excessive thirst/Fatigue
Y or N	Eye Problems	Y or N	Fever, chills, headaches
Y or N	Gout	Y or N	Hypertension/High Blood Pressure
Y or N	HIV/AIDS	Y or N	Heart Attack, Myocardial Infarction
Y or N	Heart Disease/Problems	Y or N	Hepatitis
Y or N	Hereditary Defects	Y or N	Kidney Disease
Y or N	Leg or foot ulcers	Y or N	Lung Disease
Y or N	Osteoporosis	Y or N	Pacemaker
Y or N	Rheumatoid Arthritis	Y or N	Sexually Transmitted Disease
Y or N	Skin rash/boils/problems	Y or N	Stomach problems/Reflux/GERD
Y or N	Stomach Ulcers	Y or N	Stroke
Y or N	Tuberculosis	Y or N	Tremors/Seizures/Dizziness/Epilepsy
		Y or N	Urinary Pain/Frequency/Retention

FAMILY HISTORY OF MEDICAL PROBLEMS

Please list any past family history of specific medical problems/diseases.

Mother: _____ **Died:** _____

Father: _____ **Died:** _____

Sister: _____ **Died:** _____

Brother: _____ **Died:** _____

Additional: _____ **Died:** _____

Additional: _____ **Died:** _____

PAST SURGERY HISTORY

Please list all past surgery history within the last 10 years, beginning with most recent.

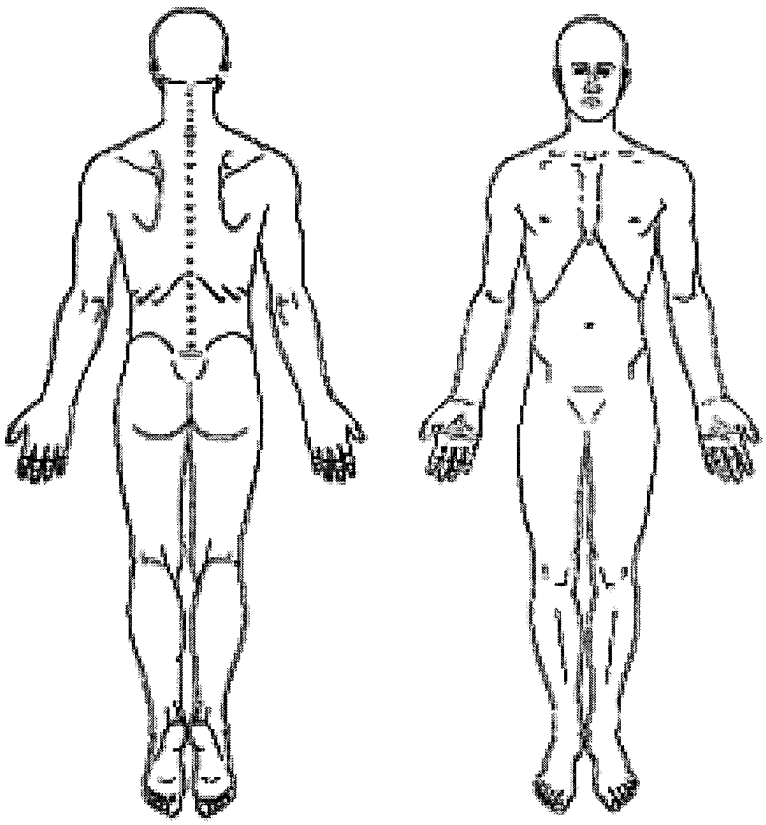
	Surgical Procedure	Date of Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Date:_____

Patient Name:_____ **DOB:**_____

Please draw the location of the pain on the body drawing. Indicate the type of pain at the location using the following.

A= Aching B=Burning S= Stabbing N=Numbness P= Pins and Needles



(Low)	0	1	2	3	4	5	6	7	8	9	10

Please indicate how you would rate the pain: