NEW PATIENT INTAKE FORM

Name: _____ **Referring Physician:** _____

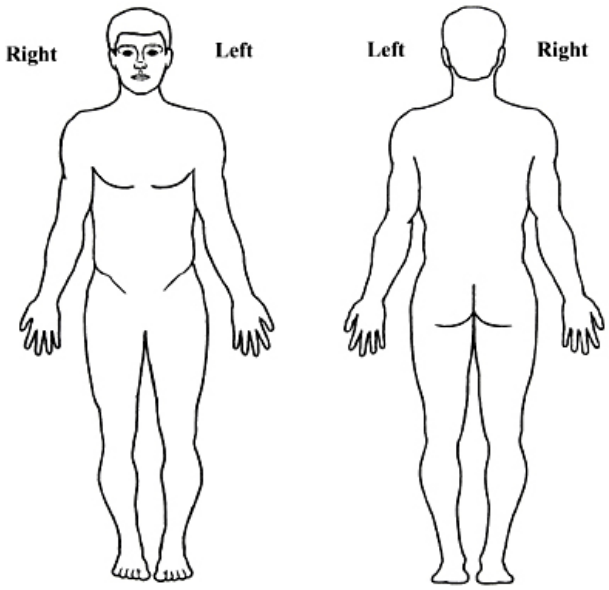
Date of Birth: _____ **Primary Care Physician:** _____

Age? _____ **Female** ☐ **Male** ☐ **Are you right or left handed?** **R** ☐ **L** ☐

What is the main problem that brings you here today (you may check more than one)?

☐ Pelvic Pain ☐ Lower Back Pain ☐ Neck Pain ☐ Mid Back Pain
☐ Abdominal Pain ☐ Vulvar Pain ☐ Leg Pain ☐ Arm Pain
☐ Widespread Pain ☐ Hip Pain ☐ Knee Pain ☐ Shoulder Pain
☐ Other – Specify: _____

On the drawings below, please shade the area where you currently experience pain.



HISTORY

When did the problem start (month/day/year)? _____

How did the problem start?

☐ Sudden Onset ☐ Gradual Onset
☐ Motor Vehicle Accident – Specify: _____
☐ Fall – Specify: _____
☐ Pregnancy related – Specify: _____
☐ Sports/Recreation – Specify: _____
☐ Other Details – Specify: _____

_____

What is the quality of your pain/symptoms?

☐ Sharp ☐ Burning ☐ Numb ☐ Tingling

☐ Aching ☐ Throbbing ☐ Dull ☐ Other – Specify: _____

Since the problem/condition began has it:

☐ Improved ☐ Changed ☐ Not Changed ☐ Worsened

On a **scale from 0 to 10 (where 10 is the worst possible pain)** how would you describe the intensity of your pain:

Average level of pain over the **last month**: _____ **Current** level of pain: _____

At your **worst,** what is your pain level: _____ At your **best** your pain is: _____

Is your pain ☐ Constant? ☐ Intermittent?

If intermittent, under what situations does the pain occur?: _____

RELIEVING AND AGGRAVATING FACTORS

Check off the following boxes depending on how the position affects your pain:

	Decrease	**Increase**
Lying Down	☐	☐
Sitting	☐	☐
Standing	☐	☐
Walking	☐	☐
Bending Forward	☐	☐
Bending Backwards	☐	☐
Changing Positions	☐	☐
Lifting	☐	☐
Going Upstairs	☐	☐
Going Downstairs	☐	☐
Sneezing or Coughing	☐	☐
Bowel Movements	☐	☐
Urination	☐	☐
Sexual Activity	☐	☐
Exercise	☐	☐

☐ Other Details (optional): _____

_____

_____

Have you ever been involved in any legal proceedings related to *this* health matter?

☐ No

☐ Yes – Specify: _____

Do you have any ***other*** legal issues? _____

Have you had any previous *major* pain issues?

☐ No ☐ Yes

Details: _____

OTHER THERAPIES

Please check all of the treatment you have tried for ***this*** problem and indicate whether the treatment provided you with any benefit.

Treatment	None	Moderate	Excellent
Physical Therapy	☐	☐	☐
Occupational Therapy	☐	☐	☐
Psychotherapy	☐	☐	☐
TENS	☐	☐	☐
Acupuncture	☐	☐	☐
Chiropractic	☐	☐	☐
Brace	☐	☐	☐
Meditation	☐	☐	☐
Biofeedback	☐	☐	☐
Massage	☐	☐	☐
Surgery (type): _____	☐	☐	☐
Injections (type): _____	☐	☐	☐
Other Exercises: _____	☐	☐	☐
Other therapies: _____	☐	☐	☐

MEDICATIONS YOU HAVE TAKEN IN *THE PAST* FOR PAIN OR MOOD

Please list any medication(s) that you have tried ***in the past*** below*:*

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

ALLERGIES

Are you allergic to latex? ☐ No ☐ Yes

Are you allergic to IV Contrast? ☐ No ☐ Yes

Do you have any other allergies? ☐ No ☐ Yes, please list below:

1. _____ **2.** _____

3. _____ **4.** _____

MEDICAL HISTORY

Current/Past medical problems:

☐ RA	☐ Osteoarthritis	☐ Osteoporosis	☐ Endometriosis
☐ Diabetes	☐ Kidney Disease	☐ Heart disease	☐ High Blood Pressure
☐ Sleep Apnea	☐ Thyroid Disorder	☐ Irritable bowels	☐ Inflammatory Bowel Disease
☐ Bleeding problems	☐ HIV/AIDS	☐ Liver disease	☐ Lung disease

☐ Cancer: What type: _____

Other Conditions:

1. _____ **2.** _____

3. _____ **4.** _____

Past Surgical History:

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

Pregnancy History (if applicable):

Are you currently pregnant? ☐ No ☐ Yes, please indicate Due Date: _____
Are you currently breast feeding? ☐ No ☐ Yes

Number of pregnancies: _____ Number of Deliveries: _____ Weight of largest baby: _____

Type of Delivery: ☐ Normal Vaginal ☐ C-section ☐ Forceps ☐ Vacuum

Number of each: # _____ # _____ # _____ # _____

Complications: _____

All Current Medications & Supplements/Herbs (name, dose, frequency)

1. _____ **2.** _____ **3.** _____

4. _____ **5.** _____ **6.** _____

7. _____ **8.** _____ **9.** _____

10. _____ **11.** _____ **12.** _____

Do you follow a special diet? ☐ No ☐ Yes, indicate type: _____

Family Medical and Psychiatric History?

☐ Chronic Pain problems? Details: _____

☐ Psychiatric Problems? Details: _____

☐ Alcohol or Drug Issues? Details: _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Have you experienced significant stress in the past year? _____

What is your living situation?(family, friends alone, etc.) _____

If you have children, what are their ages? _____

What do (or did) you do for work? _____

What is your current work status?

☐ Full Time ☐ Part Time ☐ Light-Duty ☐ Worker's Compensation ☐ Disabled ☐ Retired

Do you have difficulties functioning in your day to day life? ☐ No ☐ Yes
If yes, describe the limitations: _____

What is the highest grade you completed or degree you received? _____

Tobacco Use	☐ No	☐ Yes	Date Quit _____	If yes, #Packs/Day	_____
Alcohol Use	☐ No	☐ Yes	Date Quit _____	If yes, #Drinks/Day	_____
Other Drug Use	☐ No	☐ Yes	Date Quit _____	If yes, what type:	_____
Caffeinated Drinks	☐ No	☐ Yes	Date Quit _____	If yes, #/Day	_____

Do you exercise on a regular basis? ☐ No ☐ Yes

If yes, please indicate what you do? _____

REVIEW OF SYMPTOMS (Please mark all of the following that apply to you)

Constitutional

☐ Fever/Chills ☐ Fatigue ☐ Night sweats ☐ Loss of Appetite/Weight loss ☐ Difficulty Sleeping

Comments: _____

Head, Eyes

☐ Headaches ☐ Dizziness ☐ Head injury ☐ Blurred Vision ☐ Double Vision ☐ Abnormal Vision

Comments: _____

Ears, Nose, and Throat

☐ Sinus Pain ☐ Swollen Glands ☐ Post nasal drip ☐ Dental Issues

Comments: _____

Cardiovascular

☐ Chest Pain ☐ Palpitations ☐ Leg/ankle Swelling ☐ Fainting

Comments: _____

Respiratory

☐ Cough ☐ Asthma ☐ Shortness of Breath

Comments: _____

Neurologic

☐ Seizures ☐ Numbness ☐ Weakness ☐ Memory Problems ☐ Balance issues ☐ Speech Problems

Comments: _____

Gastrointestinal

☐ Nausea ☐ Constipation ☐ Diarrhea ☐ Abdominal pain ☐ Bowel Incontinence ☐ Blood in Stools

Comments: _____

Genitourinary

☐ Blood ☐ Pain with urination ☐ Urgency ☐ Increased frequency ☐ Incontinence ☐ Sexual Function

Comments: _____

Breast

☐ Noted breast lumps ☐ Breast tenderness ☐ Breast swelling ☐ Breast discharge

Comments: _____

Gynecological

☐ Change in menses ☐ Painful intercourse ☐ Vaginal discharge ☐ Pelvic pain

Comments: _____

Musculoskeletal

☐ Painful joints ☐ Swollen joints ☐ Joint Redness ☐ Increased warmth in joints

Comments: _____

Integumentary/Skin

☐ Sores ☐ Rash ☐ Easy Bruising ☐ Skin Cancer ☐ Psoriasis

Psychiatric

☐ Depressed ☐ Anxious ☐ Loss of interest in activities ☐ Thoughts of hurting yourself

Comments: _____

Endocrine

☐ Excessive urination ☐ Changes in energy ☐ Hair loss

Comments: _____