Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

Patient Intake Sheet

Height: _____ Weight: _____ Dominant Hand: ☐ Right ☐ Left Affected Side: ☐ Right ☐ Left ☐ Both

Referring Physician: _____ Primary Care Physician: _____

***What specific problem are you being seen for today?** _____

_____

Date of Injury / Start of Symptoms: _____ Is it getting better or worse? _____

Type of Symptoms (Check all that apply): ---------- ☐ Pain ☐ Numbness ☐ Weakness ☐ Instability ☐ Stiffness

Quality of Symptoms (Check all that apply): ---------- ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Pins and Needles

When do Symptoms occur (Check all that apply): ---------- ☐ Always ☐ Night ☐ Day ☐ Morning

Pain Level (1-10) : _____ ☐ Lifting ☐ After Activity ☐ At Rest

Have you been seen for this problem before? ☐ Yes ☐ No When? _____

Any previous treatment? ☐ Medication ☐ Splint ☐ X-Rays ☐ Injections ☐ Therapy ☐ Other:

Past Medical Problems? ☐ Hypertension ☐ Heart Disease ☐ Diabetes Mellitus ☐ Other: _____

_____

Previous Surgeries (please list): _____

Medications: _____

_____

Allergies: _____

Family History of Disease: ☐ Lupus ☐ Cancer ☐ Rheumatoid Arthritis ☐ Other: _____

Occupation: _____ How long have you been at your current job? _____

Are you currently working? ☐ Yes ☐ No Avocations (sports, activities, hobbies): _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Have you used illicit drugs? ☐ Yes ☐ No If yes what drugs? For how long?

Do you currently, or have you ever had any problems with the following? (Check all that apply)

Skin:	☐ Rashes	☐ Eczema	☐ Psoriasis	☐ Cancer		
Ears/Nose/Throat:	☐ Headaches	☐ Blurred Vision	☐ Loss	☐ Hearing Loss		
Cardiac/Heart:	☐ Palpitations	☐ Chest Pains	☐ Swollen Ankles	☐ Hypertension	☐ Rheumatic Fever	
Lungs/Respiratory:	☐ Lung Disease	☐ Emphysema	☐ Asthma	☐ Wheezing	☐ Shortness of Breath	
Gastrointestinal:	☐ Ulcers	☐ Weight Loss	☐ Abdominal Pain	☐ Blood in Stools	☐ Bowel Problems	☐ Liver Disease
Bladder/Kidney:	☐ Frequent Urination	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems		
Musculoskeletal:	☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Gout			
Conditions:	☐ Depression/Anxiety	☐ History of Cancer	☐ Fibromyalgia	☐ Other:		

***Please have intake paperwork completed 15 minutes before your appointment or you may need to be rescheduled.**

The information above is accurate to the best of my knowledge: Patient Signature: _____ Date: _____