**PATIENT INTAKE FORM**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chief Complaint:** Please check all those that apply to today’s visit

|  |  |  |
| --- | --- | --- |
| Brain | Neck/Arm/Hand | Back/Leg/Foot |
| * Headache * Seizure * Dizziness * Vision Loss * Hearing Loss * Tumor * Trauma | * Neck Pain Left Right * Arm Pain * Arm Numbness * Arm Weakness * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Back Pain Left Right * Leg Pain * Leg Numbness      * Leg Weakness |

**Allergies to Medications**: Please check any allergies that apply **or check here if none**

|  |  |
| --- | --- |
| * Penicillins | * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Vaccines**: Please check all that apply **or check here if none**

|  |  |
| --- | --- |
| * Flu Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Pneumonia Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Past Medical History:** Please check all that apply to your medial history **or check here if no to all**

|  |  |  |  |
| --- | --- | --- | --- |
| * Heart Disease * Lung Disease * Diabetes * Lyme Disease * Meningitis * Lupus * Thyroid * Hypertension * TIA * Rheumatoid Arthritis | * Major Trauma * Anxiety * Depression * Hyperlipidemia * Gout * Fibromyalgia * Shoulder Arthropathy * Epilepsy/Seizures * Parkinson’s Disease * Other: | * Stroke * Atrial Fibrillation * Asthma * COPD * Kidney Disease * Neuropathy * Hip Arthropathy * Carotid Stenosis * Tumor | * Ulcers * Osteoporosis * Cancer * Gerd * Pulmonary Embolism * DVT * Knee Arthropathy * Arthritis * Sleep Apnea |

**Surgical History:** Please check all that apply to your medical history **or check here if no to all**

|  |  |  |  |
| --- | --- | --- | --- |
| * S/P Craniotomy * Hip Replacement * Previous Stent Placement * Hernia Surgery * Thyroid Surgery | * Back Surgery * Knee Surgery * DBS * Carotid Endarterectomy * Vertebroplasty/Kyphoplasty | * Neck Surgery * Heart Surgery * VNS * Bariatric Surgery * IT Pump | * Shoulder Surgery * Pacemaker * CTR * SCS * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Diagnostic Studies:** Please check all diagnostic studies you have ad related to this visit **or check here if none**

|  |  |  |
| --- | --- | --- |
| * XRays * MRI * CT * EMG/Nerve Study * Ultrasound * Bone Scan * Myelogram | Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Location  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Review of Systems**: Please check any symptoms you have recently experienced **or check here if no to all**

|  |  |  |  |
| --- | --- | --- | --- |
| **General**   * Fever * Infection * Weight Loss * Weight Gain   **Skin**   * Swelling * Edema * Easy Bleeding or Bruising | **Chest/Lungs**   * Cough * Wheezing * Short of Breath   **Heart/Vascular**   * Chest Pain * Palpitations   **Psychological**   * Anxiety * Depression | **Musculoskeletal/Other**   * Joint Pain * Muscle Pain * Limb Weakness * Limb Numbness   **Head/Neck**   * Headache * Vision Problems * Hearing Loss * Poor Balance | **Abdomen/Intestines/Liver**   * Abdominal Pain * Nausea/Vomiting * Incontinence * Urinary Frequency * Urinary Retention * Difficulty Breathing During Exertion * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Family History**: Please check significant medical conditions in your immediate family members **or check here if no to all**

|  |  |  |  |
| --- | --- | --- | --- |
| * Heart Disease * Lung Disease | * Stroke * Cancer | * High Blood Pressure * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Diabetes |

**Social History:**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retired? Yes No Do you smoke? Yes No Do you drink regularly? Yes No