**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