ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

MEDICAL INTAKE FORM

DEMOGRAPHICS:

Patient Name: ___________________	DOB: ___________	Sex: Male / Female
Occupation: ___________________	Ht/Wt: ___________	Marital Status: ___________
Referred by: ___________________	PCP: ___________	Hand Dominance: Right / Left

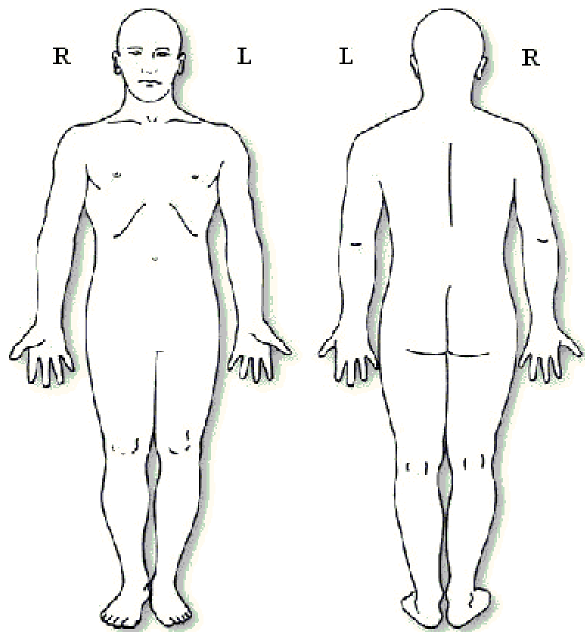
REASON FOR VISIT:

What is the main reason for your visit today: ____

____

PAIN DIAGRAM: Please indicate areas of pain, numbness, tingling, and/or burning on the following diagram (2 body part limit):

Pain= P Numbness= N Tingling= T Burning=B



SEVERITY: How severe is your pain? (Circle #)

0	1 2 3	4 5 6 7	8 9 10
No Pain	Mild	Moderate	Severe

NATURE: Pain is

❑ Occasional ❑ Continuous ❑ Intermittent
❑ Sharp ❑ Shooting ❑ Aching ❑ Dull
❑ Improving ❑ Worsening ❑ Unchanged

EFFECT ON DAILY LIFE: Does the condition

Wake you up at night? ❑ Yes ❑ No
Interfere with work activities? ❑ Yes ❑ No
Interfere with recreational activities? ❑ Yes ❑ No

INCREASING/DECREASING FACTORS:

What makes pain worse?

❑ Activity ❑ Work ❑ Exercise ❑ ______________

What makes pain better?

❑ Rest ❑Heat ❑ Ice ❑ ______________

Comments:

____

____

DETAILS OF THE CURRENT INJURY:

How did the injury/symptoms occur?

❑ Previous injury/recurrence ❑ Gradual onset ❑ Sudden/traumatic ❑ Lifting ❑ Bending ❑ Fall
❑ Twisting ❑ Whiplash ❑ Running ❑ Throwing ❑ Other: ______________________

Where did the injury occur?

❑ Home ❑ Work ❑ Sports/Recreation ❑ School ❑ Vehicle (MVA) ❑ Other ______________________

How long have you had these symptoms/injury

Date of Injury: ____________________ / How long have you had these symptoms______________________

THIRD PARTY LIABILITY:

If this was due to a motor vehicle accident, do you have an accident policy

❑ No ❑ Yes. If Yes please provide details: ______________________________

Are you seeking reimbursement from any party or insurance company for the treatment of this injury?

❑ No ❑ Yes. If Yes please provide details: ______________________________

Do you have any litigation (legal action/court case) pending for this problem/injury?

❑ No ❑ Yes. If Yes please provide details: ______________________________

DIAGNOSTIC TESTS:

Please check box and list date if you had any of the following tests performed for this problem:

❑ Xray ______________________________

❑ MRI ______________________________

❑ CT Scan______________________________

❑ Utrasound______________________________

❑ Myelogram______________________________

❑ EMG ______________________________

❑ Other______________________________

TREATMENT HISTORY:

Please check box and list date if you have tried any of the following treatments for this injury/symptoms:

❑ Cortisone injection ______________________________

❑ Epidural injection ______________________________

❑ OTC pain medication ______________________________

❑ Surgery ______________________________

❑ Physical Therapy ______________________________

❑ Chiropractor______________________________

❑ Walker/crutch/wheelchair ❑ Brace

CURRENT MEDICATIONS:

Please list name, dosage of any medications you are taking currently including prescription, over the counter, herbals:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

ALLERGIES:

Please list any/all drug and food allergies:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

ADDITIONAL INFORMATION:

If you have had any previous medical care for this issue please list

❑ Treating Dr______________________ ❑ Facility ______________________ ❑ Date ______________

❑ Treating Dr______________________ ❑ Facility ______________________ ❑ Date ______________

Additional comments: ____

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I certify that to the best of my knowledge, all information listed above is true. I further certify that I have not falsified or intentionally omitted any information related to my health or past medical history.

Signature of patient/guardian: ______________________________________ Date: ______________