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

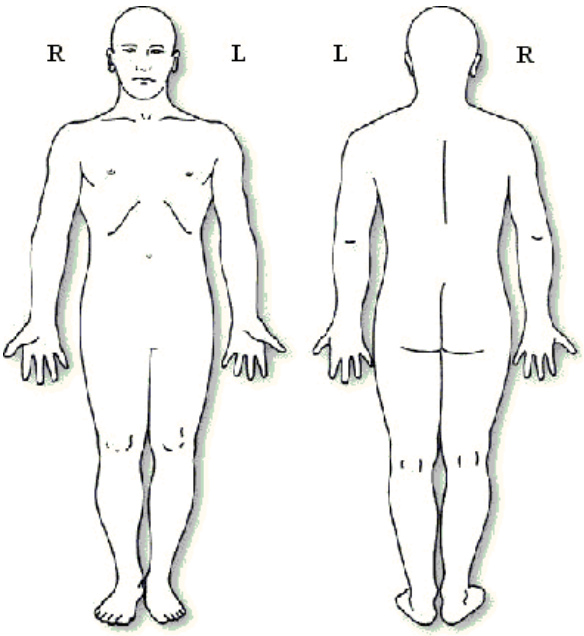
REASON FOR VISIT:

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:	**TREATMENT HISTORY:**
Please check box and list date if you had any of the following tests performed for this problem:	Please check box and list date if you have tried any of the following treatments for this injury/symptoms:
❑ Xray _____	❑ Cortisone injection _____
❑ MRI _____	❑ Epidural injection _____
❑ CT Scan_____	❑ OTC pain medication _____
❑ Utrasound_____	❑ Surgery _____
❑ Myelogram_____	❑ Physical Therapy _____
❑ EMG _____	❑ Chiropractor_____
❑ Other_____	❑ Walker/crutch/wheelchair ❑ Brace

CURRENT MEDICATIONS:	**ALLERGIES:**
Please list name, dosage of any medications you are taking currently including prescription, over the counter, herbals:	Please list any/all drug and food allergies:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	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: _____

_____

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: _____