PATIENT INTAKE AND HISTORY FORM

(Please print)

Name: _____ **Date of Birth:** _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ African-American ☐ More Than One Race
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Refused to Report/Unreported

Language: ☐ English ☐ Spanish ☐ Other_____

Pharmacy: _____
(Name/City/Phone #)

Primary Doctor: _____ **Referring Doctor:** _____

Preferred Notification Method: ☐ Mail ☐ Phone _____ ☐ Patient Portal

---

Reason(s) for coming to the doctor today:

Reason for Today's Visit: _____

Timing/Onset:

When did symptoms first occur? _____

Accident?:

Please Explain: _____

Duration:

Frequency of symptoms? _____

Characterized as/Severity:

Describe the severity of the symptoms/pain._____

Associated Signs and Symptoms:

Are there any other symptoms associated with your problem? _____

Modifying Factors:

What makes the condition better/worse? _____

Have you been treated for this condition by any other provider? If yes, please name.

Specify treatment (PT, Chiropractics, Medications, Injections, Etc.) _____

_____

Have you had any diagnostic imaging? (ie. X-ray, MRI, CT Scan, EMG)

If so, when and where: _____

Problem List/Past Medical History:

Have you been diagnosed with any of the following (currently or in the past)?

___ Alcoholism	___ Diabetes	___ Osteoporosis
___ Arthritis	___ Fibromyalgia	___ Parkinson Disease
___ Asthma	___ GERD (Reflux Disease)	___ Seizures
___ Bleeding Disorder	___ Gout	___ Sleep Apnea
___ Blood Clot	___ Heart Disease	___ Thyroid Disorder
___ Cancer	___ High Blood Pressure	___ Wound Infection
___ COPD	___ High Cholesterol	
___ Depression	___ Kidney Disease	

List any other important medical condition(s) you have had (do not include common colds or flu). Include date of initial diagnosis if possible.

Problem/Previous Diagnosis *Date(s) or Age*

_____

_____

Past Surgical History:

☐ I have not had any surgeries in the past.

Place an "X" next to any past surgical procedure you have had, and circle Left (L) or Right(R) if applicable:

		Date(s) or Age	Surgeon
___ Ankle Surgery	L R		
___ Hand Surgery	L R		
___ Carpal Tunnel Surgery	L R		
___ Arthroscopic Knee Surgery	L R		
___ Total Knee Replacement	L R		
___ Total Hip Replacement	L R		
___ Arthroscopic Shoulder Surgery	L R		
___ Total Shoulder Replacement	L R		
___ Spinal Fusion			
___ Discectomy			

___ Appendectomy ___ Hysterectomy ___ Prostatectomy

___ Hernia Repair ___ Cesarean section ___ Mastectomy L R

___ Heart Surgery ___ Cholecystectomy (Gallbladder)

___ Other (Surgery(s), Date/Age, & Surgeon): _____

_____

_____

Allergy History:

☐ **None** ☐ **NKDA (No Known Drug Allergies)**

___ Anesthesia ___ Iodine ___ Penicillin ___ Sulfa Drugs ___ Adhesive Tape

___ Contrast Dye ___ Latex ___ Shellfish ___ Other: _____

Medication History:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, and herbs that you are currently taking:

Name of Medication	Dosage	Name of Medication	Dosage

Family History:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Bleeding Disorder	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes Mellitus	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
HIV Infection	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____

List any other important family medical condition(s) you are aware of (do not include common colds or flu). Include date of initial diagnosis if possible:

Family Member *Medical Condition / Date of Initial Diagnosis*

_____

_____

_____

Have you or anyone in your family(mother, father, sister, brother) ever had a reaction to anesthetic, general or local, causing high fever(malignant hyperthermia), blood pressure problems, hepatitis or any other type of allergic reaction?
Yes ___ No ___ If yes, please explain: _____

Social History:

Are you? ☐Employed ☐Retired ☐Student (Employed) ☐Student (Unemployed) ☐Homemaker ☐Unemployed ☐Disabled

If applicable: Who is your current employer? _____ Job Title: _____

Do you use tobacco (Cigarettes, Cigars, Chewing Tobacco, etc.)? ☐Yes ☐No

If yes, please indicate what type of tobacco and how often: _____

Do you drink alcoholic beverages? ☐Yes ☐No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☐Yes ☐No

If yes, please indicate what type of drug and how often: _____

Please describe your highest education level attained?

☐Less than high school ☐High school graduate ☐Some college ☐College graduate ☐Postgraduate ☐Unknown

Please describe your current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Vigorous

If you do have a current exercise routine, how many times per week: _____

Please describe your hobbies and interests?

_____

_____
