**Patient Intake Form**

All sections are mandatory, and I need ALL areas listed in THIS order please. The red lettering will be where the Red boxes are on your current form, but I want them changed as I have them. The blue lettering is text I want inserted, or text in drop downs. The black lettering is instruction

Demographics

Name:

Age:

Gender:

I don’t think we need the “Select the Provider” here, as the patient will have already done that

Chief Complaint

Problem Area

Dropdown - The patient needs to be able to choose maximum of 2 body parts

-finger

-hand

-wrist

-forearm

-elbow

-upper arm

-shoulder

-neck

-back

-pelvis/hips

-upper leg

-knee

-lower leg

-ankle

-foot

-toe

History of Present Illness

What are your symptoms?

Dropdown – may choose a maximum of 2 symptoms

-sharp pain

-dull pain/achiness

-numbness/tingling

-weakness

-instability

-popping/clicking

-catching

Did you have an injury or did symptoms come about slowly?

Freetext

How long has it been bothering you?

Freetext

When does it bother you?

Dropdown menu

-with certain activities

-daytime

-nighttime

-all the time

What makes the symptoms better or worse?

Freetext

What treatments have you had so far?

Freetext

Any other pertinent information regarding the current symptoms?

Freetext

Past Medical History

List your current or past medical problems; that is, anything you take prescription or over the counter medication for, or anything you see a physician or specialist for

Freetext

Are you currently in a pain management program for this problem or another chronic pain issue?

Freetext

Past Surgical History

List ALL surgeries you’ve had in the past

Freetext

Medications

List ALL current medications, both prescription and over the counter, including vitamins and supplements

Freetext

Do you take NSAIDS (aspirin, Aleve, naproxen, Motrin, ibuprofen or other anti-inflammatories not including Tylenol)

Dropdown - Yes or No

Can you take NSAIDS?

Dropdown – Yes or No

Do you have a history of ulcers or kidney disease?

Dropdown – Yes or No

Do you currently take a blood thinner?

Dropdown – Yes or No

Allergies

Specifically are you allergic to any medication, medical products, or IV contrast/dye?

Freetext

Social History

Do you use tobacco, alcohol or recreational drugs? If so, what types and how much? (how many packs per day do you smoke, how many drinks per day, etc)

Freetext

Do you live alone?

Dropdown – Yes or No

Are you employeed?

Dropdown – Yes or No

Are you pregnant?

Dropdown – Yes or No

Family History

Do you have a first degree relative with any major medical problems (explain)?

Freetext

Review of Systems

Please try to answer ALL questions

Do you have nausea, vomiting, fever, chills, diarrhea, or other symptoms of a generalized illness or infection?

Freetext

Is there redness, swelling or bruising at the area of chief complaint?

Freetext

Is the skin in tact, is there scabbing, drainage or any other skin changes at the area of chief complaint?

Freetext

Is there deformity at the area of chief complaint?

Freetext

Do you have full mobility of the body part/joint at the area of chief complaint?

Freetext

Do you have any feelings of instability at the area of chief complaint?

Freetext

Can you put your full weight on the area of chief complaint?

Freetext

Physical Characteristics

Please try to answer ALL questions

Height

Weight

Dominant Hand

Dropdown – Right or Left

Video Exam

(will be filled out by physician after review of the patients video)

Assessment

(will be filled out by physician after review of the patients history and intake form and review of the video)

Recommendations

will be filled out by physician after review of the patients history and intake form and review of the video)