NEW PATIENT INTAKE FORM

Name: _____ Age: _____ Date: _____
Primary Care Physician: _____
Referred By: _____
Preferred Pharmacy: _____

What is your chief symptom or problem? _____
Location of Pain/Problem: _____
What factors make the pain/problem worse? _____
_____
When did the pain/problem start (date)? _____

Please rate the severity or intensity of pain (circle number):

0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

The pain is present: ❒ Constantly ❒ Intermittently ❒ At Night
The quality of pain is: ❒ Sharp ❒ Dull ❒ Burning ❒ Other
How did the symptoms/condition start? _____
_____
_____

Pain IMPROVES with _____ Pain WORSENS with _____
****

Systems Review – Please indicate "Yes" or No." If answer is "Yes," please describe the problem.

		YES	NO	TYPE
1.	Recent cold or flu?	____	____	_____
2.	Recent skin problems?	____	____	_____
3.	Recent eye/ear problem?	____	____	_____
4.	Recent nerve problem?	____	____	_____
5.	Recent depression/anxiety?	____	____	_____
6.	Recent respiratory problem?	____	____	_____
7.	Recent heart problem?	____	____	_____
8.	Recent intestinal problem?	____	____	_____
9.	Recent urinary problem?	____	____	_____
10.	Recent bleeding problems?	____	____	_____

ALLERGIES (please list what you are allergic to and the type of reaction): _____
_____
_____

CURRENT MEDICATIONS

Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

SUPPLEMENTS (e.g. St. John's Wort, Ginseng, Creatine): _____

Name: _____ Date: _____

PAST MEDICAL HISTORY – Please indicate "Yes" or "No"

CONDITION	YES	NO
Coronary Artery Disease		
High Blood Pressure		
Heart Attack		
Murmur		
Pacemaker		
Heart Failure		
Irregular Heartbeat		
Hyperlipidemia		
Stroke		
Seizure		
Kidney Failure		
Diabetes		
Thyroid Disease		

CONDITION	YES	NO
Gout		
Cancer		
If yes, Type:		
Asthma		
Tuberculosis		
Emphysema		
Hepatitis		
Ulcer		
GI Bleed		
Anemia		
Bleeding Disorder		
Deep Vein Thrombosis		

PAST SURGICAL HISTORY

Type of Surgery	Date of Surgery	Surgeon
_____	_____	_____
_____	_____	_____

PAST FAMILY HISTORY – Please indicate "Yes" or "No" if it pertains to an immediate family member only (e.g. parent, sibling, or grandparent)

CONDITION	YES	NO	RELATIONSHIP
Coronary Artery Disease			
High Blood Pressure			
Heart Attack			
Stroke			
Diabetes			
Thyroid Disease			
Cancer			
Hepatitis			
Anemia			
Bleeding Disorder			

SOCIAL HISTORY

Tobacco Use: ❒ Current Smoker ❒ Former Smoker ❒ Never Smoker
If Yes, Type: ❒ Cigarette ❒ Pipe ❒ Cigar ❒Other _____
# of Packs per day: _____ # of years smoking: _____

Alcohol Use: ❒ Yes ❒ No
If yes, # of Drinks per ❒ Day ❒ Week ❒ Month: _____

OTHER: Sports/Exercise: Type: _____ # Days/Week _____ Duration per Session: _____
High School: _____
College: _____
Occupation: _____
❒RIGHT-handed ❒LEFT-handed

For Office Use:
❒ IB ❒ Nap ❒Cel ❒ Vic-5 ❒ Vic-7
PT: _____
Brace: _____
Disability Status: OW _____ Lt Duty _____
F/Up In: _____