# PATIENT MEDICAL INTAKE

**Name:** _____ **Date of Birth:** __/__/____ **Age:** _____

**Chief Complaint / Current Illness (Why are we seeing you today):**

_____

**Date of Onset of Symptom(s):** _____
**Work Related Injury:** ◯ Yes ◯ No Skip A-E if No

A) Job Title: _____
B) How long have you worked for this employer? _____
C) Date of injury: _____
D) Are you: ◯ Off Work ◯ Modified duty ◯ Full duty
E) If you are not full duty, what date did you last do so? _____

If **PAIN** is one of your complaints, please answer the following

**Rate the average intensity of your pain/discomfort (0 is no pain, 10 is severe pain):**

0 1 2 3 4 5 6 7 8 9 10

**Describe your pain:**

◯ Intermittent ◯ Constant ◯ Dull ◯ Sharp ◯ Throbbing
◯ Tight ◯ Burning ◯ Tingling ◯ Clicking/Popping

**Is your pain worse at any particular time of day?** ◯ Morning ◯ Evening ◯ Night
**Is it worse with any particular activity?** _____
**Describe any other additional symptoms (bruising, numbness, locking, swelling, stiffness):**

_____

**Have you tried any of the below for your condition?**

**Medication:** ◯ Yes ◯ No Type: _____
**Physical Therapy:** ◯ Yes ◯ No If yes, how long did you attend? _____
When was your last session? _____
**Injections:** ◯ Yes ◯ No if yes, location and medication? _____
**Other:** ◯ Yes ◯ No Describe: _____

**Please list all medications you currently use with dosage and frequency:**

_____ _____
_____ _____
_____ _____

**Have you had any allergic reactions to medication?**

**If YES, list medication and reaction:** ◯ Yes ◯ No

_____
_____

**What is your preferred pharmacy?** _____ **Cross Streets?:** _____

# PATIENT MEDICAL HISTORY

**Please mark all that apply:**

| | | | | |
|---|---|---|---|---|
| ◯ Heart Problems | ◯ Gout | ◯ Bleeding Disorder | ◯ Liver Problems | ◯ Other |
| ◯ High Blood Pressure | ◯ Seizures | ◯ Serious Injuries | ◯ Thyroid Problem | |
| ◯ Stroke | ◯ Sleep Apnea | ◯ Lung Disease | ◯ Phlebitis | |
| ◯ Diabetes | ◯ CPAP | ◯ Asthma | ◯ Blood Clots | |
| ◯ Arthritis | ◯ Kidney Problems | ◯ Anemia | ◯ AIDS/HIV | |
| ◯ Cancer | ◯ Osteoporosis | ◯ Stomach Ulcers | ◯ Hepatitis/Jaundice | |

**Surgeries/Hospitalizations:**

1. _____
2. _____
3. _____
4. _____
5. _____

**Problems with Anesthesia in the past?** ◯ Yes ◯ No **Describe:** _____

**When was your last Influenza Immunization (Flu Shot)?** _____

**When was your last Pneumonia Vaccination?** _____

**FAMILY MEDICAL HISTORY** (Mark if any of these run in your family)

| | | | |
|---|---|---|---|
| ◯ Heart Problems | ◯ Stroke | ◯ Arthritis | ◯ Mental Illness |
| ◯ Alcoholism | ◯ Diabetes | ◯ Gout | ◯ Kidney Problems |
| ◯ Cancer | ◯ High Blood Pressure | ◯ Seizures | ◯ Bleeding |

**PATIENT SOCIAL HISTORY**

**Married / Single** **Do you live alone?** ◯ Yes ◯ No If no, who do you live with? _____

**# Of Children:** ____ **Do you exercise regularly?** ◯ Yes ◯ No How Often? _____

**Tobacco Use?** ◯ Yes ◯ No Type: _____

Amount per day: _____ # of years used: _____ Quit Date: _____

**Alcohol Consumption?** ◯ Yes ◯ No # of drinks/week: _____ **History of Alcoholism?** ◯ Yes ◯ No

**Recreational/Drug Usage** ◯ Yes ◯ No

# REVIEW OF SYSTEMS

**(Recent or Current conditions only)**

- ◯ Weight Change
- ◯ Fever/Chills
- ◯ Weakness
- ◯ Urinary Burning
- ◯ Irregular Periods
- ◯ Blackouts
- ◯ Insomnia
- ◯ Chronic Infection
- ◯ Anxiety
- ◯ Backache
- ◯ Ear Pain/Ringing
- ◯ Nosebleeds
- ◯ Night Sweats
- ◯ Poor Appetite
- ◯ Seizures
- ◯ Numbness
- ◯ Visual Changes
- ◯ Depression
- ◯ Joint Pain
- ◯ Abnormal Heartbeat
- ◯ Shortness of Breath
- ◯ Cough
- ◯ Hoarseness
- ◯ Nausea/Vomiting
- ◯ Tooth/Gum Trouble
- ◯ Rash
- ◯ Pregnant
- ◯ Chest Pain
- ◯ Lumps/Masses
- ◯ Incontinence
- ◯ Urinary Frequency
- ◯ Stomach Pain
- ◯ Frequent Headaches
- ◯ Difficulty Swallowing
- ◯ Frequent Diarrhea
- ◯ Frequent Constipation
- ◯ Blood in Stools
- ◯ Joint/Limb Swelling

_____ I acknowledge that I have received the Notice of Privacy Practice of Active Orthopedic, which explains its legal duties and privacy practices with respect to my protected health information.

By signing below, I agree that all the information provided is true to the best of my knowledge. I also authorize my insurance benefits to be paid directly to the physician and I am financially responsible for the non-covered services. I also authorize the physician to release any information required to process this claim.

**Patient / Responsible Party Signature:** _____ **Date:** _____

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**I have reviewed the above in detail with the patient**

**Physician Signature;** _____ **Date:** _____

**Patient Name:** _____ **Chart#:** _____

# REVIEW OF SYSTEMS

**Have you ever suffered from:**

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain / Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Lumps in Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of Breath
- ☐ Sinus Infection
- ☐ Sleep Problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

| | |
|---|---|
| A = Ache | O = Other |
| B = Burning | P = Pins & Needles |
| N = Numbness | S = Stabbing |



FRONT



BACK