

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 Name: _____ **Chart#:** _____

PATIENT MEDICAL HISTORY

Please mark all that apply:

- | | | | | |
|---|---------------------------------------|---|--|-----------------------------|
| <input type="radio"/> Heart Problems | <input type="radio"/> Gout | <input type="radio"/> Bleeding Disorder | <input type="radio"/> Liver Problems | <input type="radio"/> Other |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Seizures | <input type="radio"/> Serious Injuries | <input type="radio"/> Thyroid Problem | |
| <input type="radio"/> Stroke | <input type="radio"/> Sleep Apnea | <input type="radio"/> Lung Disease | <input type="radio"/> Phlebitis | _____ |
| <input type="radio"/> Diabetes | <input type="radio"/> CPAP | <input type="radio"/> Asthma | <input type="radio"/> Blood Clots | _____ |
| <input type="radio"/> Arthritis | <input type="radio"/> Kidney Problems | <input type="radio"/> Anemia | <input type="radio"/> AIDS/HIV | _____ |
| <input type="radio"/> Cancer | <input type="radio"/> Osteoporosis | <input type="radio"/> Stomach Ulcers | <input type="radio"/> 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)

- | | | | |
|--------------------------------------|---|---------------------------------|---------------------------------------|
| <input type="radio"/> Heart Problems | <input type="radio"/> Stroke | <input type="radio"/> Arthritis | <input type="radio"/> Mental Illness |
| <input type="radio"/> Alcoholism | <input type="radio"/> Diabetes | <input type="radio"/> Gout | <input type="radio"/> Kidney Problems |
| <input type="radio"/> Cancer | <input type="radio"/> High Blood Pressure | <input type="radio"/> Seizures | <input type="radio"/> 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)

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

_____ 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:** _____

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

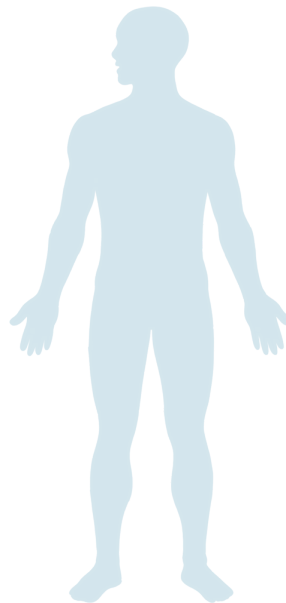
B = Burning

N = Numbness

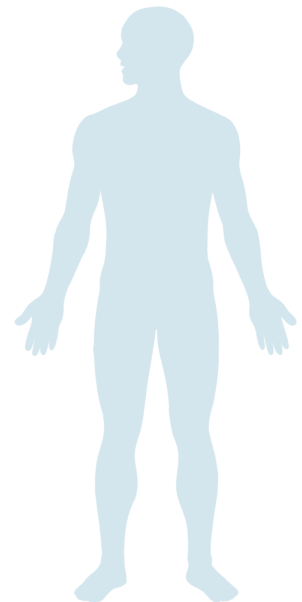
O = Other

P = Pins & Needles

S = Stabbing



FRONT



BACK

