

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

Surgeries/Hospitalizations:

- _____
- _____
- _____
- _____
- _____

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

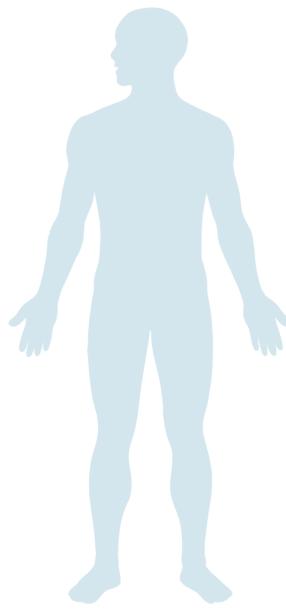
O = Other

B = Burning

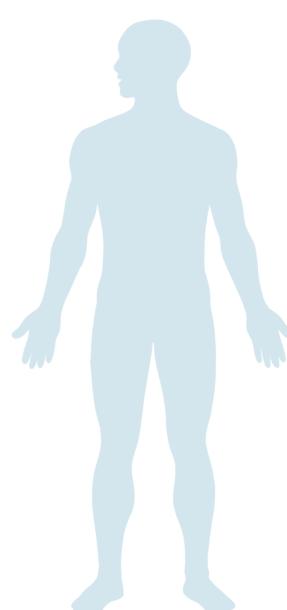
P = Pins & Needles

N = Numbness

S = Stabbing



FRONT



BACK

