CHIEF COMPLAINT INTAKE SHEET

NAME:_____**TODAY'S DATE:**_____ **BIRTHDATE**_____

PRIMARY CARE PHYSICIAN:_____ **REFERRED BY:**_____

REASON FOR TODAY'S VISIT/CHIEF COMPLAINT(S):_____

BODY PART _____ **RIGHT or LEFT or BOTH (Circle One)**

DATE OF ONSET/INJURY: _____ **EXPLAIN HOW THE PAIN/INJURY STARTED BELOW:**

_____

WHAT SYMPTOMS ARE YOU EXPERIENCING? (Circle all that apply)

STABBING PAIN	TENDERNESS	TWINGING	SORENESS	ACHING	BRUISING
CONSTANT PAIN	REDNESS	INSTABILITY	BUCKLING	GIVING WAY	SHOOTING PAIN
INTERMITTENT PAIN	POPPING	CLICKING	NUMBNESS	TINGLING	KNOT OR CYST
PAIN INCREASES AT NIGHT		GRINDING	LOCKING	THROBBING	LOSS OF MOTION
PAIN INCREASES WITH ACTIVITY		SWELLING	WEAKNESS	STIFFNESS	CATCHING
PAIN INCREASES W/WEIGHT BEARING		RADIATING PAIN UP/DOWN		TIGHTNESS	SHARP PAIN

PLEASE MARK ALL CONSERVATIVE TREATMENT YOU HAVE TRIED AND IF YOU NOTICED ANY IMPROVEMENT:

TRIED:	**IMPROVEMENT?**		**TRIED:**	**IMPROVEMENT?**	
____ICE	☐ YES	☐ NO	____SPLINTING/BRACING	☐ YES	☐ NO
____HEAT	☐ YES	☐ NO	____STRETCHING	☐ YES	☐ NO
____REST	☐ YES	☐ NO	____MASSAGE	☐ YES	☐ NO
____SITTING	☐ YES	☐ NO	____NSAIDS (IBUPROFEN)	☐ YES	☐ NO
____LAYING	☐ YES	☐ NO	____TYLENOL	☐ YES	☐ NO
____WALKING	☐ YES	☐ NO	____PARTIAL WEIGHT BEARING	☐ YES	☐ NO
____INJECTIONS	☐ YES	☐ NO	____PHYSICAL THERAPY	☐ YES	☐ NO
____ELEVATION	☐ YES	☐ NO	____OTHER_____	☐ YES	☐ NO

HAVE YOU BEEN TREATED BY ANOTHER PHYSCIAN OR FACILITY FOR THIS PROBLEM? ___YES or ___NO
IF SO, PLEASE LIST PROVIDER(S) AND TREATMENT(S): _____
_____

WERE X-RAYS AND/OR MRI OBTAINED? __YES or __NO **IF SO, WHEN AND WHERE:**_____
WAS SURGERY PERFORMED? __YES or __NO **IF SO, WHEN AND WHERE:**_____

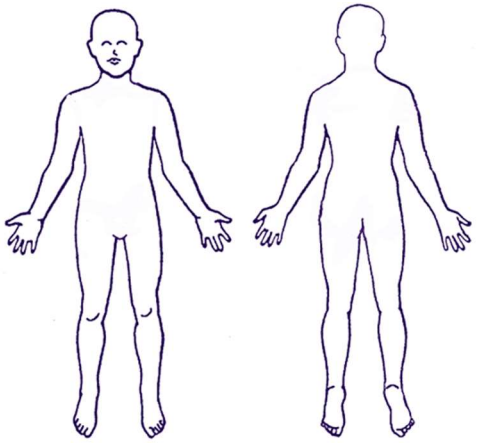
CIRCLE THE NUMBER ON THE LINE BELOW THAT REPRESENTS YOUR PAIN <u>RIGHT NOW</u>.

0 1 2 3 4 5 6 7 8 9 10

No pain **Moderate** **Severe** **Excruciating**

<u>INDICATE ON THE DIAGRAM</u>

<u>WHERE YOUR PAIN IS LOCATED.</u>



IS THIS INJURY/CONDITION WORK RELATED? ___**YES or** ___**NO**
IS THIS INJURY/CONDITION IN RELATION TO AN AUTO ACCIDENT OR 3RD PARTY LIABILITY? ___**YES or** ___**NO**

PERSONAL MEDICAL HISTORY

NAME:_____**TODAY'S DATE:**_____ **BIRTHDATE**_____

HEIGHT:_____**WEIGHT:**_____ **RIGHT or LEFT HANDED (circle one)**

LIST ALL PRIOR SURGERIES: **DATE**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

LIST ALL ALLERGIES:_____

WORK STATUS (circle one): FULLTIME PART TIME RETIRED STUDENT UNEMPLOYED DISABLED

ARE YOU CURRENTLY TAKING COUMADIN, XARELTO, PLAVIX, AGGRENOX, ASPIRIN, ELIQUIS OR LOVENOX?
___YES or ___NO

ARE YOU CURRENTLY UNDER THE CARE OF A CARDIOLOGIST? ___YES or ___NO

IF YES, WHO IS YOUR CARDIOLOGIST?_____ **DATE OF LAST APPT:**_____

DO YOU HAVE A PACEMAKER OR ANY METAL IN YOUR BODY? YES OR NO **IF SO, LIST:**_____

ARE YOU CLAUSTROPHOBIC? ___YES or ___NO

DO YOU USE TOBACCO PRODUCTS? ___YES or ___NO **IF SO, WHAT KIND?** _____
HOW MANY YEARS? _____ **HOW MUCH?** _____

DO YOU DRINK ALCOHOL? ___YES OR ___NO **IF SO, HOW MUCH?**_____

MEDICAL HISTORY (*PLEASE CHECK ALL THAT APPLY **CURRENTLY OR IN THE PAST*)**

___ANXIETY
___ARTHRITIS
___ASTHMA
___BACKACHES
___BLOOD DISORDER
___BLOOD IN STOOL
___CANCER
___CLAUSTROPHOBIA
___COPD
___DEPRESSION
___DIABETES
___OTHER_____
___DVT
___EPILEPSY
___FRACTURE
___GERD
___GI DISEASE
___GLAUCOMA
___GOUT
___HEAD INJURY
___HEART ATTACK
___HEART DISEASE
___HEPATITIS
___HIATAL HERNIA
___HIGH BLOOD PRESSURE
___HIGH CHOLESTEROL
___INFECTIOUS DISEASE
___KIDNEY DISEASE
___LIVER DISEASE
___MENTAL DISORDER
___MIGRAINES
___MITRAL VALVE PROLAPSE
___PACEMAKER
___PROSTATE DISEASE
___PULMONARY EMBOLISM
___REFLUX
___RHEUMATIC FEVER
___SEIZURE DISORDER
___SHORT OF BREATH
___SKIN RASH
___STRESS
___STROKE
___TB
___THYROID DISEASE
___ULCERS
___UTI

DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE A HISTORY OF: (circle all that apply)

HEART DISEASE DIABETES TB CANCER HIGH BLOOD PRESSURE STROKE ASTHMA SEIZURES
BLEEDING DISORDER THYROID DISEASE KIDNEY DISEASE MENTAL ILLNESS

Name: _____ Date of Birth: _____ ACCT #: _____

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	**Dosage** *Example: 10.5 mg*	**How Often do you take the Medication?** *Once daily, every 4 hours, every 12 hours, etc.*	**How do you take?** *By mouth, apply to skin, inhale, under tongue, injection, etc*	**Type:** *Tablet, Capsule, patch, drops, ointment, spray, liquid, etc.*	

DATE: _____ Patient initials: _____