PATIENT INTAKE FORM

Patient's Name: ______________________________ Age: __________ Today's date: ______________

Current family physician/internist: ______________________________ Ht.________ Wt. __________

Reason for seeing doctor **(location)**: ______________________________right / left / both (circle)

Date of **onset**/injury: ______________________________

Was there an injury? ____________________ Is the injury related to work / auto / other (circle)

Precipitating event/**cause (explain)**? ______________________________

Have you tried any medications, injections, **treatment** and/or therapy for the problem? ______________

____

What makes the problem worse (**aggravating factors/limitations**)?______________________________

Does anything make the problem better? ______________________________

Pain Scale: Rate (Circle): None 1 2 3 4 5 6 7 8 9 10 Severe

Course/Progression? Improving / unchanged / worsening (circle)

Have you had any testing for the problem: X-ray, MRI, labs, CT scan, etc.?
What / Where? ______________________________

Pharmacy location: (name / city / cross streets / phone number)

____

I declare the above is correct to the best of my knowledge:______________________________
Patient / parent / guardian signature

Doctor's Notes:

General:

Mental Status: **ROM**: flex: ext: HypExt:
(A/P)

General Appearance: ER: IR: aBd:

Orientation: person: place: time: PF: DF: In: Ev:

Build/Nutrition: musc: ln: ob: pet: Fsup: Fpro: TL:

Integumentary: ecch: eryth: HI: II: lacer: **Instability**: ADr: Lach: PvSh:

OpIn: psor: rash: valgus: varus: TL:

Peripheral/Vasc: *Inspection* ery: gang: ulcer: AI: PI: Sulc: Crank: MDI:

Palpation Hom: pulse: edema: **Strength**: flex: ext: ER: sup:

Neurologic: DF: PF: In: Ev: TL:

Gait: Abnl. Asst. Dev. **Functional Testing**: McM: Thess: Thom: SLR:

Inspect/Palp: Tend: Swl: Eff: Crep pwrWE: pwrLFE: pwrWF:

Deformity/Malalign/Discrep: LLD: r<l:_______ l<r:_______ Tin: Phal: Fink: GrT: FroS:

var: valg: ett: pPl: pCv: hv: Hgd: Imp: ACca: blt: LO: ACT: O'b: