

Patient Intake Form

Please complete the following:

Name: _____ Date _____

What is your average pain level:
0(no pain)>10(worst pain imaginable)

Without Meds: _____ With Meds: _____

Comfort level: _____ Poor Fair Good

Functional Status: _____ Poor Fair Good

Since your last visit, pain is: _____ Same Better Worse

What makes your pain worse: _____

What makes your pain better: _____

Do you have numbness? _____ Yes No

Where? _____

Do you have muscle weakness? _____ Yes No

Where? _____

Medications from **THIS** office:

Name of Medications	Daily Dose
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List side effects from meds: _____

Medications from other MD's:

Name of Medications	Daily Dose
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Date of last injection: _____

Did it help? _____ Yes No

For how long? _____

Have you used a TENS? _____ Yes No

Are you currently using a TENS? _____ Yes No

Have you seen a Psychologist or Psychiatrist? _____ Yes No

Name: _____ Currently? _____ Yes No

Have you had Physical Therapy? _____ Yes No

When? _____ Did it help? _____ Yes No

List diagnostic procedures, new medical problems and dates of hospitalization since your last visit: _____

Work Status: Are you currently working? _____ Yes No

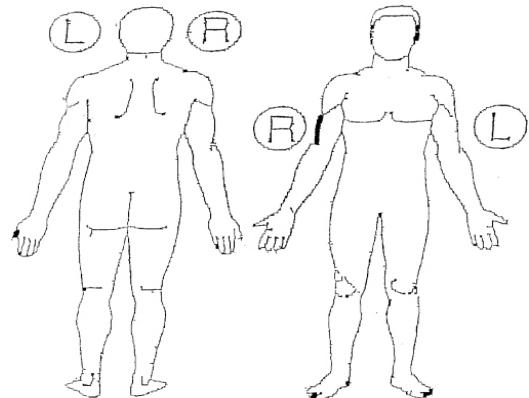
If not, when did you stop working? _____

Who took you off work? _____

Review of Systems:

<p>GENERAL:</p> <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <p>SKIN</p> <input type="checkbox"/> Itching <input type="checkbox"/> New Lesions <input type="checkbox"/> Rash <p>HEENT</p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Headache <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Sore Throat <p>NECK</p> <input type="checkbox"/> Neck Pain <input type="checkbox"/> Neck Stiffness <p>RESPIRATORY:</p> <input type="checkbox"/> Cough <input type="checkbox"/> Snoring <input type="checkbox"/> Wheezing <p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations	<input type="checkbox"/> Shortness of Breath <p>GASTROINTESTINAL</p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Bloody Stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <p>GENITOURINARY</p> <input type="checkbox"/> Flank Pain <input type="checkbox"/> Frequency <input type="checkbox"/> Incontinence <input type="checkbox"/> Painful Urination <input type="checkbox"/> Urgency <p>MALE (ONLY)</p> <input type="checkbox"/> Impotence <input type="checkbox"/> Testicular pain <p>MUSCULOSKELATAL:</p> <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Back Pain <input type="checkbox"/> Calf Pain <input type="checkbox"/> Decreased ROM <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Redness <input type="checkbox"/> Joint Stiffness	<p>MUSCULOSKELATAL:</p> <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Swelling of Extremities <p>NEURO:</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Paresthesias <input type="checkbox"/> Unusual Sensation <input type="checkbox"/> Weakness <p>PSYCH:</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood Changes <input type="checkbox"/> Insomnia <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Suicidal Planning <input type="checkbox"/> Previous Suicide Attempts <p>ENDOCRINE:</p> <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Libido Change <input type="checkbox"/> Thyroid Problems
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Shade in the area where you have pain:



Additional Problems/Notes: _____

Comments/Questions for this visit: _____

Signature _____

Date _____



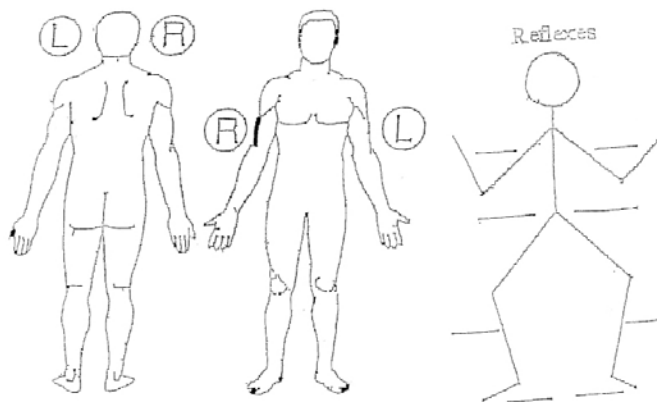
Patient Name _____ Date _____

Progress Notes

Physical Exam:

BP _____ P _____ R _____ T _____ WT _____ HT _____

	ROM	Tenderness
Head		
Neck		
Back		
EXT.		



Neuro

Level of Consciousness ___ Normal ___ Decreased

Oriented x 3

CN 2-12 ___ Intact ___ Deficit

Motor ___ WNL ___ Deficit

Sensory ___ WNL ___ Deficit

Reflexes ___ WNL ___ Deficit

<u>Impression:</u> <input type="checkbox"/> Radicular Pain <input type="checkbox"/> Facet Syndrome <input type="checkbox"/> Discogenic Pain <input type="checkbox"/> RSD/CRPS <input type="checkbox"/> Other
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