



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? _____

BP _____ / _____ R _____ P _____ T _____

HT _____ W _____

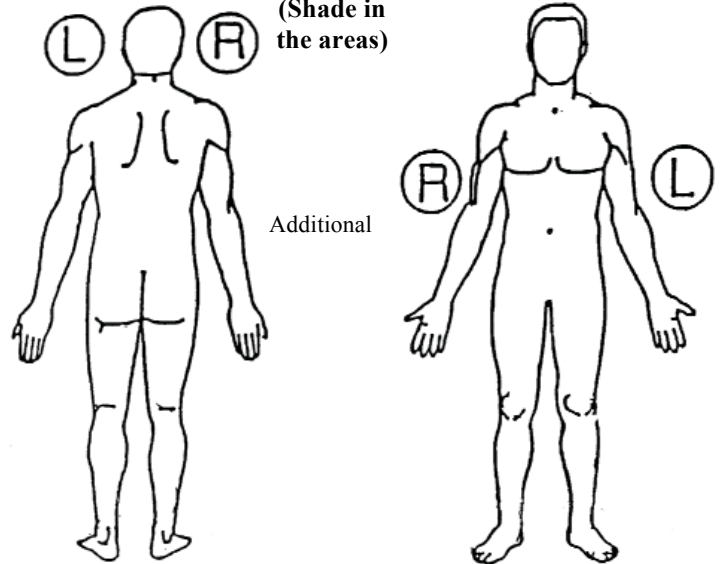
Review of Systems: Provider Signature/Date

_____/_____

General: ___ Fever ___ Fatigue ___ Dry Mouth ___ Appetite EYE: ___ Eye redness R L ___ Dec. Vision R L ___ Photophobia ENT: ___ Sinus pain R L ___ Sinus congestion ___ Stiff neck ___ Ear Ache R L ___ Dec. Hearing R L ___ Sore Throat CV: ___ Chest Pain ___ Palpitations	Respiratory: ___ Cough ___ Wheezing ___ Shortness of breath GI: ___ Abd pain ___ Nausea ___ Vomiting x ___ Diarrhea x ___ Constipation ___ Melena - BRBPR GU: ___ Dysuria ___ Hematuria ___ Urg &/or frequency ___ Penile D/C ___ Impotence ___ Incontinence SKIN: ___ Rash - urticaria	GYN: N/A (male) LMP ___ Vaginal D/C ___ Vaginal bleeding Musculoskeletal: ___ Back pain ___ Muscle soreness ___ Joint <i>pain swelling</i> Neuro: ___ Headache ___ Dizziness ___ Weakness Psych: ___ Depressed - anxious ___ Stressed Out ___ Loss of Memory Endocrine: ___ Too hot - too cold ___ Change in hair ___ Weight lbs
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Where you have pain:

(Shade in the areas)



Problems/Notes: _____

Comments/Questions for this visit: _____

I verify the information is complete and accurate:

Signature _____ Date _____

DICTATED NOT DICTATED