INTAKE FORM

☐Dr J.Axe ☐Dr M..Axe ☐Dr.Bodenstab ☐Dr.Brady ☐Dr.Crain ☐Dr.Ginsberg ☐ Dr. Gotha☐Dr.Handling ☐ Dr. Johnson ☐ Dr. Kahlon
☐Dr.Leitman☐Dr.Manifold ☐Dr.Moran ☐ Dr. Mavrakakis ☐ Dr. Newell ☐ Dr. Pan ☐Dr. Puskarewicz ☐Dr.Raisis
☐Dr.Rudin ☐Dr. Smucker ☐Dr.Sowa ☐Dr.Steele ☐Dr.Straight☐Dr.Tooze ☐Dr. Zaslavsky

PATIENT INFORMATION

Date: __________ **Name:** ______________________________________ **Age:** ________ **FSO MR #:** ________________

REASON FOR VISIT - Ort Home

Body Part(s): ____ **☐ Right ☐ Left ☐ Bilateral**

Complaint: ☐ Pain ☐ Injury ☐ Fracture ☐ Numbness ☐ Swelling ☐ Other: ____

HISTORY OF PRESENT INJURY - HPI: This Chief Complaint

(Please check all that apply)

Have you been off work for this problem?: ☐ Yes ☐ No **Dates off work**: ____

Doctors who have treated you for this problem: __________________________________ **Did that doctor refer you here?**: ☐ Yes ☐ No

Diagnostic tests and treatment performed *(please list when/where/what)*: ☐ X-Ray _______________________ ☐ MRI ________________________________

☐ Injection _________________ ☐ Surgery: _________________ ☐ NSAIDS (anti-inflammatories) _________________ ☐ EMG _______________________

☐ CT/Scan _______________ ☐ Bone Scan _______________ ☐ Lab Work _______________ ☐ Other: _______________ ☐ PT _____________________

Have you ever had similar problems? If yes, please give details: ____

Onset/Date of Injury: __________________ **Context**: ☐ No Injury ☐ Injury ☐ Sports Injury ☐ MVA - Details:____________________________________

Severity:	☐ Mild	**Status**:	☐ Changing	**Frequency**:	☐ Intermittent	**Quality**:	☐ Aching
	☐ Mild-Moderate		☐ Improving		☐ Occasional		☐ Burning
	☐ Moderate		☐ Fluctuating		☐ Constant		☐ Dull
	☐ Moderate-Severe		☐ Resolved		☐ Rare		☐ Piercing
	☐ Severe		☐ Stable				☐ Sharp
			☐ Worse	**Radiation**:	☐ Yes ☐ No		☐ Throbbing
				Radiates To: _______________			

Aggravated By:	**Relieved By**:	**Associated Symptoms / Pertinent Negatives:**		
☐ Bending	☐ Brace/Splint	☐ Bruising	☐ Numbness	
☐ Climbing Stairs	☐ Elevation	☐ Crepitus (cracking sounds)	☐ Popping	
☐ Decending Stairs	☐ Exercise	☐ Decreased Mobility	☐ Spasms	
☐ Lifting	☐ Heat	☐ Difficulty going to sleep	☐ Swelling	
☐ Movement	☐ Ice	☐ Instability	☐ Tingling in the arms	
☐ Pushing	☐ Injection	☐ Limping	☐ Tingling in the legs	
☐ Sitting	☐ Massage	☐ Locking	☐ Tenderness	
☐ Standing	☐ Pain/Rx Meds: ______________	☐ Night Pain	☐ Weakness	
☐ Walking	☐ Mobility	☐ Night-time awakening	☐ Other: _____________	
☐ Other: _____________	☐ OTC Meds: __________________			
	☐ PT		**Hand Dominanc**	
	☐ Rest		☐ Right ☐ Left	
	☐ Stretching		☐ Ambidextrous	
	☐ Other: _____________________			

REVIEW OF SYSTEMS - Add Additional ROS

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:		**Metabolic/Endocrine:**		**Neurological:**		**Immunological:**	
	☐ Fatigue		☐ Cold Intolerant		☐ Difficulty Walking		☐ Enviromental Aller
	☐ Fever		☐ Heat Intolerant		☐ Dizziness		☐ Food Allergies
	☐ Night Sweats	**HEENT:**		**Hematologic/Blood:**			
Cardiovascular:			☐ Headache		☐ Bleeding	☐ **None**	
	☐ Chest Pain		☐ Vision Loss	**Respitory:**			

	☐ Cyanosis (blue coloration of skin)	**Gastrointestinal:**		☐ Cough	
	☐ Irregular Heartbeats/Palpatations		☐ Constipation	☐ Dyspnea	
Integumetary/Skin:			☐ Diarrhea	**Genitourinary:**	
	☐ Rash		☐ Nausea	☐ Dysuria	
			☐ Vomiting	☐ Hematuria	

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PATIENT'S MEDICAL CONDITION - Assistant Doc>Vital Signs

Height: ___ ft ___ in **Weight:** _ ___ lbs **Blood Pressure:** ____ / ____ **List details of any diet program:** ______________________________

My weight in the last 6 months has: ☐ **Not Changed** ☐ **Increased _____lbs.** ☐ **Decreased _____lbs.**

Have you ever taken any anti-inflammatories/arthritis medications?: ☐Yes ☐No (**Ex**: Naprosyn/Ibuprofen) If yes, please list: ________________________

ALLERGIES - Assistant Doc>Add Allergy

(Please check all in which you have an allergy and list the reaction - hives, nausea, anaphylaxis, etc)

Reaction:	Reaction:	Allergy & Reaction:
☐ Aspirin ____________________	☐ NSAIDs ____________________ (anti-inflammatories - ibuprofen, naprosyn)	☐ Other: ____________________
☐ Codeine ____________________	☐ Narcotics ____________________ (Percocet, Vicodin)	☐ Other: ____________________
☐ IV Dye ____________________	☐ Penicillin ____________________	☐ Other: ____________________
☐ Latex ____________________	☐ Sulfa ____________________	☐ **No Known Drug Allergies**

PATIENT'S MEDICAL HISTORY - Histories>Additional History

(Please check all that apply)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimers
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hyertrophy
- ☐ Cancer
- ☐ Cerebrovascular Accident (Stroke)
- ☐ Congestive Heart Failure (CHF)
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Degenerative Joint Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ DVT (Blood Clot)
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Bowel Disease
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyme Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Peptic Ulcer Disease
- ☐ Psoriasis
- ☐ PVD
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ SLE (Lupus)
- ☐ Spinal Stenosis
- ☐ Thyroid Disease
- ☐ Valvular Disease (Heart valve problems)
- ☐ **None**
- ☐ Other:
  - ____________
  - ____________
  - ____________
  - ____________
  - ____________
  - ____________

PATIENT'S SURGICAL HISTORY - Histories>Additional History

(Please check all that apply)

- ☐ ACL Surgery
- ☐ Angioplasty
- ☐ Angio w/stent
- ☐ Appendectomy
- ☐ Athroscopy (Scope) Details:
  - ________________________
- ☐ Back Surgery - Details:
  - ________________________
  - ________________________
- ☐ CABG
- ☐ Cardiac (Heart) Valve Replacement
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Cholecystectomy (gallbladder removal)
- ☐ Colectomy
- ☐ Colostomy
- ☐ Discectomy
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Laminectomy
- ☐ LASIK
- ☐ Meniscus Surgery
- ☐ Muscle Biopsy
- ☐ Neck Surgery - Details:
  - ____________________
  - ____________________
- ☐ ORIF
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy

Gender Specific

Female

- ☐ Cesarean Section
- ☐ Hysterectomy
- ☐ Mastectomy

Male

- ☐ Prostatectomy
- ☐ TURP

- ☐ Other:
  - ____________________
  - ____________________
  - ____________________
  - ____________________
  - ____________________
- ☐ **None**

PATIENT'S FAMILY HISTORY - Histories> Additional Family History

Is your Father Living? ☐ Yes ☐ No If no, age deceased ________ cause of death ______________________________

Is your Mother Living? ☐ Yes ☐ No If no, age deceased ________ cause of death ______________________________

Are any of your brothers/sisters deceased? ☐ Yes ☐ No If yes, age deceased _______ cause of death ______________________________

Family history of chronic/inherited diseases: ____

PATIENT'S SOCIAL HISTORY - Histories>Social History

Tobacco Use: ☐ Yes ☐ No ☐ Former/Year Quit _______

Consume Alcohol: ☐ Yes ☐ No ☐ Former/Year Quit _______

Activity Level: ☐ Sedentary ☐ Moderate ☐ Vigorous

Type of Exercise: _________________________ _______________________

SIGNATURE

Date: __________________ **Signature of Patient, Parent or Guardian:** ____

[redacted]										
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