



INTAKE FORM

Dr. Axe Dr. Bodenstab Dr. Brady Dr. Crain Dr. Handling Dr. Hershey Dr. Johnson Dr. Kahlon Dr. Katz
Dr. Kim Dr. Moran Dr. Newcomb Dr. Pushkarewicz Dr. Raisis Dr. Rudin Dr. Sowa Dr. Steele Dr. Straight

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

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

REVIEW OF SYSTEMS - Add Additional ROS

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

Constitutional: Fatigue Fever Night Sweats
Cardiovascular: Chest Pain Cyanosis (blue coloration of skin) Irregular Heartbeats/Palpitations
Integumentary/Skin: Rash
Metabolic/Endocrine: Cold Intolerant Heat Intolerant
HEENT: Headache Vision Loss
Gastrointestinal: Constipation Diarrhea Nausea Vomiting
Neurological: Difficulty Walking Dizziness
Hematologic/Blood: Bleeding
Respiratory: Cough Dyspnea
Genitourinary: Dysuria Hematuria
Immunological: Enviromental Allergies Food Allergies
Other: None

PATIENT'S MEDICAL CONDITION - Assistant Doc>Vital Signs

Height: ___ft ___in Weight: _____lbs. My Weight in the last 6 months has: Not Changed Increased _____lbs. Decreased _____lbs.

Please list details of any special diet program: _____

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:
<input type="checkbox"/> Aspirin _____	<input type="checkbox"/> NSAIDs _____ (anti-inflammatories - ibuprofen, naprosyn)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Codeine _____	<input type="checkbox"/> Narcotics _____ (Percocet, Vicodin)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> IV Dye _____	<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Latex _____	<input type="checkbox"/> Sulfa _____	<input type="checkbox"/> No Known Drug Allergies

PATIENT'S MEDICAL HISTORY - Histories>Additional History

(Please check all that apply)

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

PATIENT'S SURGICAL HISTORY - Histories>Additional History

(Please check all that apply)

<input type="checkbox"/> ACL Surgery	<input type="checkbox"/> CABG	<input type="checkbox"/> Hip Replacement	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Cardiac (Heart) Valve Replacement	<input type="checkbox"/> Knee Replacement	<input type="checkbox"/> Small Bowel Resection	_____
<input type="checkbox"/> Angio w/stent	<input type="checkbox"/> Carpal Tunnel Release	<input type="checkbox"/> Laminectomy	<input type="checkbox"/> Thyroidectomy	_____
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cataract Extraction	<input type="checkbox"/> LASIK	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Athroscopy (Scope) Details: _____	<input type="checkbox"/> Cholecystectomy (gallbladder removal)	<input type="checkbox"/> Meniscus Surgery	Gender Specific	
<input type="checkbox"/> Back Surgery - Details: _____ _____	<input type="checkbox"/> Colectomy	<input type="checkbox"/> Muscle Biopsy	Female	_____
	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Neck Surgery - Details: _____	<input type="checkbox"/> Cesarean Section	_____
	<input type="checkbox"/> Discectomy		<input type="checkbox"/> Hysterectomy	_____
	<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Mastectomy	_____
	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> ORIF	Male	_____
			<input type="checkbox"/> Prostatectomy	_____
			<input type="checkbox"/> TURP	<input type="checkbox"/> 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: _____