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Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (408) 528-8833 if you have questions on how to complete any section of this form.

Today's Date: ________________________________

Referring Physician: ___________________________

Primary Care Physician: _______________________

☐ **Referred by Internet/Website**

First name:	Last name:	Marital status:
City:	State:	Zip:
Social Security:	Mobile Number:	Alternative Number:
Birth Date:	Age:	Sex (circle): Male Female
Occupation:	Employer:	Employer Phone:

Emergency Contact

Name:	Relationship:	Phone Number:

Insurance Information

Insurance Carrier:	Subscriber ID:	Group Number:
Secondary Insurance:	Subscriber ID:	Group Number:

Occupational Injury (Work Comp)

Date of Injury:	Claim Number:	Insurance Carrier:
Employer:	Adjuster Name:	Adjuster Phone:

Personal Injury

Date of Injury:	Insurance Carrier:	Policy Number:
Claim Number:	Attorney Name:	Attorney Phone:
Att'y Address:	City:	Attorney Fax:

HISTORY (Pain|Spine|Orthopedic|Injury)

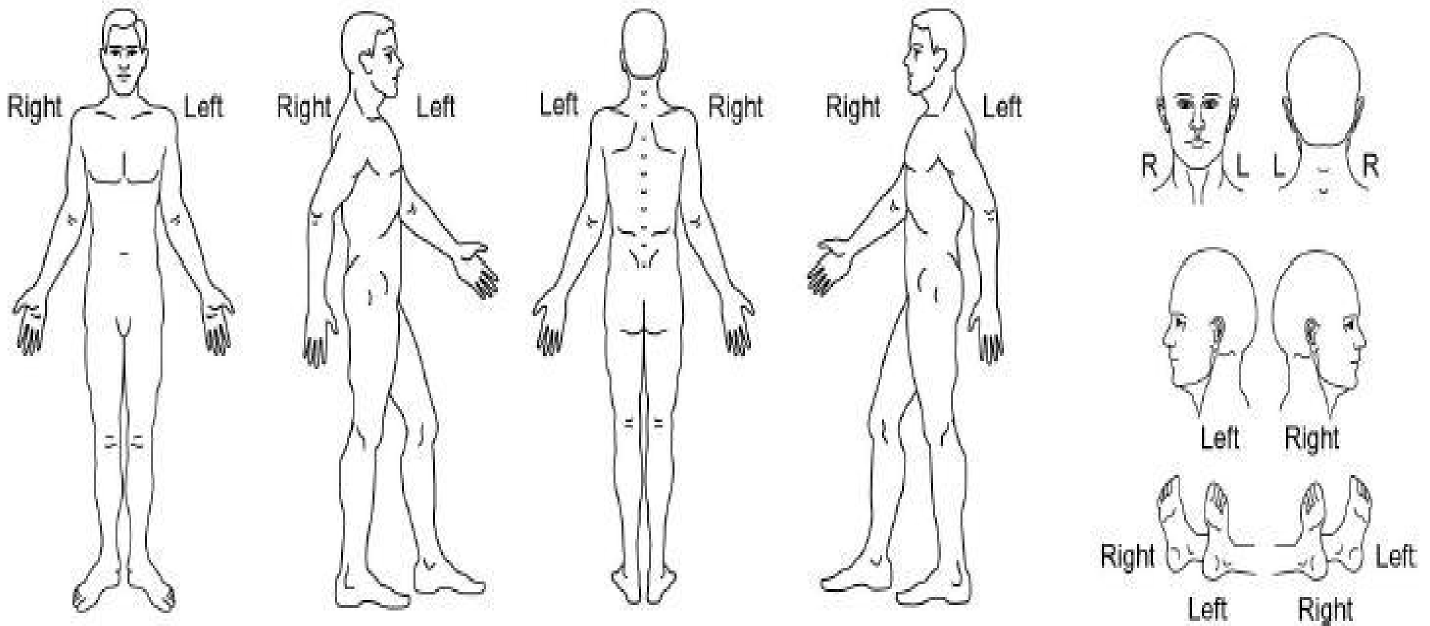
Chief complaint (reason for visit today):

____

Please list any additional pain issues or involved body part(s):

____

Use the body outlines below to draw the location(s) of your pain and direction(s) that pain travels (if applicable).



Using the **following** "key" to describe quality of pain (mark on diagrams):

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
///	BBB	NNN	XXX	+++	OOO

How did your symptoms begin?

☐ Suddenly ☐ Gradually ☐ Combination

Approximately how long ago did your pain/symptoms begin?

☐ Days ☐ Weeks ☐ Months ☐Years ☐ Date: _______________

Describe onset of injury or symptoms: *(If related to injury, please indicate location or setting and describe mechanism)*

____

____

How often does your pain occur?

☐ Constant/Daily ☐ Intermittent (comes and goes)

Circle your level of pain intensity:

Least Pain___0____1____2____3____4____5____6____7____8____9____10____Worst Pain

Associated symptoms:

☐ Numbness/Tingling Location(s): ____________________

☐ Weakness Location(s): ____________________

☐ Bowel/Bladder Incontinence Location(s): ____________________

☐ Other __________________

Please mark all treatments you have used for pain relief:

☐ Medication(s): ____

☐ Physical therapy ☐ Chiropractic therapy ☐ Acupuncture ☐ Psychological therapy

☐ Massage therapy ☐ Brace support ☐ Hot/cold packs ☐ TENS unit

☐ Trigger point injection(s):
Location: _______________
Date(s): _______________

☐ Joint injection(s):
Location: _______________________
Date(s): ________________________

☐ Epidural steroid injection(s):
Location: __________________
Date(s):___________________

☐ Medial branch blocks/Facet joint Injections:
Level(s): ______________________
Date(s): _______________________

☐ Rhizotomy/Radiofrequency Ablation (RFA)
Level(s) _______________________
Date(s): _______________________

☐ Spinal cord stimulator
Area involved: __________________
Date(s): ________________________

☐ Vertebroplasty/Kyphoplasty
Area involved: _________________
Date(s): _______________________

☐ Spine/Orthopedic surgery
Area involved:_____________
Date(s)___________________

☐ Prolotherapy
Location(s):_______________
Date(s): _________________

☐ Botox
Location(s):__________________
Date(s): ______________________

☐ PRP/Stem cells
Location(s):__________________
Date(s): _____________________

☐ Other: __________________

Mark diagnostic studies you have had related to current complaints:

☐ NONE

☐ MRI Body Part: ________________ Date: _______________

☐ X-ray Body Part: ________________ Date: _______________

☐ CT scan Body Part: ________________ Date: _______________

☐ EMG/NCS Body Part: ________________ Date: _______________

CURRENT MEDICATION(S)

Are you taking any medication? ☐ Yes ☐ No

(If you have a written list we can copy it for you.)

Medication____________________________ Strength/Dose_______________

Medication____________________________ Strength/Dose_______________

Medication____________________________ Strength/Dose_______________

Medication____________________________ Strength/Dose_______________

Medication____________________________ Strength/Dose_______________

Medication____________________________ Strength/Dose_______________

Medication____________________________ Strength/Dose______________

PAST MEDICAL HISTORY

☐ NONE

☐ Anemia	☐ Anxiety	☐ Asthma	☐ Atrial Fibrillation
☐ Bipolar Disorder	☐ Blood Clot/DVT	☐ Bronchitis/Pneumonia	☐ Cancer:
_______________________			
☐ Carpal Tunnel Syndrome	☐ Cataracts	☐ Chronic Join Pain	☐ Constipation
☐ Coronary Artery Disease	☐ Depression	☐ Diabetes Mellitus	☐ Diverticulosis
☐ Emphysema/COPD	☐ Endometriosis	☐ Fibromyalgia	☐ Gastrointestinal Bleeding
☐ GERD (Acid Reflux)	☐ Glaucoma	☐ Gout	☐ Head/Brain Injury
☐ Headaches	☐ Heart Attack	☐ Heart Valve Disorder	☐ Hepatitis B
☐ Hepatitis C	☐ High Blood Pressure	☐ HIV	☐ Hyperlipid/Cholesterolemia
☐ Hyperthyroidism	☐ Hypothyroidism	☐ Insomnia	☐ Kidney Stone(s)
☐ Lupus (SLE)	☐ Migraines	☐ Multiple Sclerosis	☐ Osteoarthritis
☐ Osteoporosis	☐ Overactive Bladder	☐ Parkinson's	☐ Peripheral Neuropathy
☐ Peripheral Vascular Disease	☐ Rheumatoid Arthritis	☐ Sciatica	☐ Seizures
☐ Sleep Apnea	☐ Stomach Ulcer	☐ Stroke/TIA	☐ Tuberculosis
☐ Other: ____			

ALLERGIES/INTOLERANCE

☐ NONE

List drug/substance and associated reactions for all allergies:

1) ____
2) ____
3) ____
4) ____

SURGICAL HISTORY

☐ NONE

☐ Abdominal Hernia Repair
☐ Aneurysm Repair: Type___________
☐ Angioplasty w/Stent
☐ Ankle/Foot Surgery: Type__________
☐ Appendectomy
☐ Bladder Surgery
☐ Bowel Surgery
☐ Brain Tumor Resection
☐ Breast Biopsy
☐ Bunionectomy
☐ Cardiac Pacemaker
☐ Carpal Tunnel Release (LEFT)
☐ Carpal Tunnel Release (RIGHT)
☐ Cataract Removal
☐ Cesarean Section (C-section)
☐ Deviated Septum Repair
☐ Elbow Surgery: Type____________
☐ Fibroid Removal
☐ Fracture/Pins/ORIF: Location:_______
☐ Gallbladder Removal (Cholecystectomy)
☐ Gastric Bypass or Stapling
☐ Gout Tophus Removal
☐ Heart Valve Surgery
☐ Hip: Type______________
☐ Hysterectomy
☐ Inguinal Hernia Repair
☐ Kidney Stone Removal
☐ Knee: Type_________
☐ Kyphoplasty
☐ Lasik
☐ Low back/Lumbar Spine: Type_______
☐ Mastectomy
☐ Neck/Cervical Spine: Type__________
☐ Open Heart Surgery (Bypass)
☐ Pilonidal Cyst Excision
☐ Shoulder: Type____________
☐ Spleen Removal (Splenectomy)
☐ Thyroidectomy
☐ Tonsillectomy
☐Trigger Finger Release: ______________
☐ Tubal Ligation
☐ Wisdom Teeth Extraction
☐ Other: ___________________________

FAMILY HISTORY

List significant medical disease in 1st degree relatives:

1) ____________________________________
2) ____________________________________
3) ____________________________________

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Children: ☐ Yes ☐ No
Tobacco Use: ☐ No ☐ Yes: Packs per day________________________________
Alcohol Use: ☐ Never ☐ Occasionally/Socially ☐ Daily
Illegal Drug Use: ☐ Never ☐ Yes Type: ___________ Last Use: ___________
Exercise: ☐ Never ☐ 1-2 times/ week ☐ 3+ times/week

WORK HISTORY (Required for all WORK COMP cases)

☐ Retired
Current Occupation: ____
Employer: ____
Work Duties: ____
How long have you worked at current position: _______________
Work Status:
☐ Full Duty ☐ Temporary Disability ☐ Permanent Disability ☐ Unemployed
☐ Modified-----------------→ Restrictions: ____

REVIEW OF SYSTEMS (Please check all that apply)

General
- ☐ Change in appetite
- ☐ Chills
- ☐ Fevers
- ☐ Lightheadedness
- ☐ Weight gain
- ☐ Weight loss
- ☐ Sleep disturbance

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Bowel incontinence

Head/Eyes/Ears/Nose/Throat
- ☐ Decreased hearing
- ☐ Decreased sense of smell
- ☐ Difficulty swallowing
- ☐ Ringing in ears
- ☐ Sinus pain
- ☐ Sore throat

Urologic
- ☐ Painful urination
- ☐ Bladder incontinence
- ☐ Blood in urine
- ☐ Increased urinary frequency
- ☐ Increased urinary urgency

Musculoskeletal
- ☐ Joint Pain(s)
- ☐ Generalized weakness
- ☐ Wasting
- ☐ Swelling of joints

Neurologic
- ☐ Balance difficulty
- ☐ Headaches
- ☐ Dizziness
- ☐ Seizures

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Fluid accumulation in legs
- ☐ Palpitations (heart fluttering)

Skin
- ☐ Discoloration
- ☐ Rash
- ☐ Skin lesion(s)
- ☐ Excessive sweating

Psychiatric
- ☐ Depressed mood
- ☐ Anxiety