INTAKE FORM

Date: ______________________

Referred By: ______________________________

Name: First ____________________ Last Name____________________

Date of Birth: ____________ Age: _______

Sex: ( ) Male ( ) Female Hand Dominance: ( ) RT handed ( )LT handed

Preferred Pharmacy Name: ________________________Pharmacy Location: ___________________

Reason for today's visit ____________________________________ (please be specific on what body part)

Date of Injury: ____________ Work Related: ( ) Yes ( )No

How did accident happen and where: ___________________________

Where you involved in a car accident: ( )Yes ( )No

Ortho Imaging: ( ) X-rays ( )MRI ( )Bone Scan ( )CT ( )Ultrasound Date:_________Facility_______________

Lab Studies: Facility___________________________ Date:_________________________

Answer these questions if you are 65 years of age or older:

- 2 or more falls in the past year ( )Yes ( )No
- 1 fall in the past year with injury ( )Yes ( ) No

MEDICAL HISTORY

( )Arthritis Type: ( )Rheumatoid ( )Osteo ( )Juvenile ( )Gout ( )Lupus
( )Anemia Type: ( )Iron Deficiency ( )Blood loss ( )Sickle Cell ( )Vitamin Deficiency
( )Bleeding disorders Type: ( )Clotting Problems ( )Abnormal Bleeding
( )CancerType: ( )Breast ( )Leukemia ( )Lung ( )Gastric ( )Colon ( )Lymphoma ( )Prost ate ( )Myeloma
( )Are you being treated for Cholesterol : ( ) Yes ( )No
( )Depression Type: ( )Biopolar Disorder ( )Major Depression ( )Persistent Depressive Disorder
( )Diabetes Type: Insulin ( )Yes ( )No
Diseases of the Heart: Type: ( ) Atrial Fibrillation ( ) Coronary Heart Disease ( )Angina ( )Heart Attack ( )Arrhythmia
( ) Hypertension ( )Stroke
Diseases of the Liver : Type: ( )Cirrhosis ( )Gallstones ( )Hepatitis ( )Fatty Liver
Diseases of the Lung: Type: ( ) Asthma ( )Bronchitis ( )COPD ( )Cystic Fibrosis ( )Emphysema ( )Pneumonia
( ) Tuberculosis ( )Pulmonary Vascular Disease
Diseases of Stomach: Type: ( ) Gastritis ( )Ulcers ( )Hiatal Hernia ( )Colitis ( )Reflux ( )Constipation ( )Crohn's
( ) Diverticulitis
Diseases of Thyroid: Type: ( ) Hyperthyroidism ( )Hypothyroidism ( )Goiter

( ) NONE OF THE ABOVE

ALLERGIES

( ) Penicillin ( )Sulfa ( )Cortisone ( )Latex ( ) Adhesives ( )None ( )Other ____________________

SURGICAL AND ORTHOPAEDIC HISTORY

( )Thyroid ( )Cancer ( )Hysterectomy ( )Heart ( )Lung ( )Kidney ( )Colon ( )Gallbladder ( )Other __________

( ) NONE OF THE ABOVE

Bone and Joint: Type: Joint: ( ) Total Hip ( )Total Knee ( )Total Shoulder

Bone: ( )Ankle ( )RT ( )LT ( )Both
( )Hand ( )RT ( )LT ( )Both ( )Carpal Tunnel ( )RT ( )Left ( )Both
( )Wrist ( )RT ( )LT ( ) Both
( )Elbow ( )RT ( )LT ( )Both
( )Forearm ( )RT ( )LT ( )Both
( )Foot ( )RT ( )LT ( )Both
( )Femur ( )RT ( )LT ( )Both
( )Tibia ( )RT ( )LT ( )Both
( )Shoulder ( )RT ( )LT ( )Both ( )Rotator Cuff Repair ( )RT ( )LT ( )Both
( )Knee ( )RT ( )LT ( )Both ( )Knee Arthroscopy ( )RT ( )LT ( )Both
( )NONE OF THE ABOVE

Spine: Type: ( ) Cervical ( )Lumbar ( )Scoliosis ( )NONE

FAMILY HISTORY

Hypertension ( )Mother ( )Father ( )Sister ( )Brother ( )Maternal grandparent ( ) Paternal grandparent

Diabetes ( )Mother ( )Father ( )Sister ( )Brother ( )Maternal grandparent ( ) Paternal grandparent

Arthritis ( )Mother ( )Father ( )Sister ( )Brother ( )Maternal grandparent ( ) Paternal grandparent

Heart Disease ( )Mother ( )Father ( )Sister ( )Brother ( ) Maternal grandparent ( ) Paternal grandparent

Dementia ( )Mother ( )Father ( )Sister ( )Brother ( ) Maternal grandparent ( ) Paternal grandparent

Osteoporosis ( )Mother ( )Father ( )Sister ( )Brother ( ) Maternal grandparent ( ) Paternal grandparent

( )NO FAMILY HISTORY

SOCIAL HISTORY

Cigarette Smoking
( ) Never Smoked
( ) Quit
( ) Smokes less than daily
( ) Smokes daily #of packs a day ____

Alcohol Use
( ) Don't Drink
( ) Less than one drink a day
( ) 1-2 drinks a day
( ) 3 or more drinks a day

Exercise Frequency
( ) Several times a day
( ) Once a day
( ) Few times a week
( ) Few times a month

MEDICATIONS

( ) Brought list of medication ( )Not currently taking any medications

Medication Name	Dosage	Number times dosage per day

OFFICE USE ONLY

Height	Weight	BP	Pulse	Respiratory	B M I

PHYSICIAN'S NOTES