Name_____ Date ___/___/_____ Clinical Intake Form

Past Medical History- check all that apply to you

___ Anemia	___ Depression	___ Lymphoma
___ Anxiety	___ Diabetes; insulin	___ Multiple myeloma
___ Asthma	___ Diabetes; no insulin	___ Obesity
___ Atrial fibrillation	___ End stage renal disease	___ BPH (enlarged prostate)
___ Bipolar disorder	___ GERD	___ Prostate cancer
___ Breast cancer	___ Hepatitis	___ Pulmonary embolus
___ Cardiac; hyperlipidemia	___HIV/AIDS	___ Radiation therapy
___ Cardiac; heart disease	___ Hypercholesterolemia	___ Rheum: Fibromyalgia
___ Chronic pain	___ Hyperparathyroidism	___ Rheumatoid arthritis
___Colon cancer	___ Hypertension	___ Sleep apnea
___ COPD	___ Hyperthyroidism ___ Hypothyroidism	___ Seizures
___ Coronary artery disease	___ Leukemia	___ Stroke
___ D V T	___ Lung cancer	___ Other

___ None of the above

Past Surgical History- check all that apply to you

___ Appendectomy	___ Gastric bypass band reduction sleeve	___ Prostate
___ Breast lumpectomy/mastectomy left right bilateral	___ Heart coronary bypass valve:biologic/mechanic PTCA: angioplasty/stent Transplant	___ Rectum APR(anterior posterior) Low anterior
___ Breast implants reduction	___ Kidney stone nephrectomy L R transplant L R	___ Skin Basal cell Squamous cell Melanoma
___ Colectomy Cancer Diverticulitis Other bowel disease	___ Liver transplant other surgery	___ Tonsillectomy
___ Colostomy	___ Ovaries removed ovarian cancer	___ Uterus hysterectomy C section uterine Ca cervical Ca
___Gallbladder (cholecystesctomy)	___ Pancreas	___ Other

___ None of the above

Last menstrual period ____/____/_____ Are you pregnant yes no don't know

Musculoskeletal History - check all that apply to you

___ Ankle fracture L R	___ Hip fracture L R	___ RSD
___ Ankylosing Spondylitis	___ HNP cervical	___ Sciatica
___ Adhesive capsulitis L R	___ HNP lumbar	___ Scoliosis
___ Bursitis L R	___ Metastatic bone disease	___ Shoulder impingement
___ Carpal tunnel synd L R	___ Osteoarthritis (DJD)	___ Spine fracture
___ Chronic back pain	___ Osteopenia	___ Soft tissue sarcoma
___ DISH	___ Osteoporosis	___ Spinal stenosis, cervical
___ Radius fracture L R	___ Polio	___ Spinal stenosis, T/lumbar
___ Epidural spine injection	___ Primary bone sarcoma	___ Vertebral compression fracture
___ Fracture(broken bone)	___ Psoriatic arthritis	___ Vitamin D deficiency
___ Gout	___ Rheumatoid arthritis	___ Wrist fracture
___ Handedness ambi L R	___ Rickets	___ Other

___ None of the above

Musculoskeletal Surgery- check all that apply to you

___ Achilles repair L R	___ Total hip L R	___ Meniscus repair L R
___ ACL reconstruction L R	___ Total knee L R	___ Reverse shoulder L R
___ Ankle fracture ORIF L R	___ Total shoulder L R	___ Revision hip surg L R
___ Bunion surgery L R	___ Knee arthroscopy L R	___ Revision knee L R
___ Carpal tunnel surg L R	___ Kypho/vertebrplasty	___ Revision shoulder L R
___ C spine fusion	___ Lumbar fusion	___ Rotator cuff surg L R
___ C spine disc replacement	___ Lumbar laminectomy	___ Shoulder arthroscopy L R
___ CMC arthroplasty L R	___ Lumbar decompression	___ Trigger finger L R
___ Distal radius ORIF L R	___ Lumbar decompression and fusion	___ Other
___ Ganglion cyst L R	___ Lumbar disc replacement	
___ Femur fracture ORIF L R		
___ Tibia fracture ORIF L R		
___ Arm fracture ORIF L R		

___ None of the above

Family History- check all that apply to you

	Mother	Father	Sister	Brother	Daughter	Son	Other
Charcot Marie Tooth							
Diabetes							
Hypertension							
Multiple Hereditary Exostosis (Olliers)							
Osteoarhritis							
Osteoporosis							
Rheumatism							
Scoliosis							
Other							

___ None of the above

Interventional Pain History- check all that apply to you

___ ESI Cerv Thor Lumb	___ Medial branch block Cerv Thor Lumb	___ Spinal cord stimulator
___ Facet inj Cerv Thor Lumb	___ Rhizotomy Cerv Thor Lumb	___ Other
___ Intrathecal pump		

___ None of the above

Medicines Please list ALL current medications or check the option which applies

___ I brought a medicine list that included name, dosage, and how I take it
___ I am not taking any medications

Medication Name	Dosage	How and how often do you take it

Allergies Please list ALL allergies or check option which applies

___ I brought an allergy list that includes the allergen name and my reaction to it
___ I have No known allergies

Allergy	Describe allergic reaction, severity, and symptoms

Social History

Cigarette smoking
___ Never ever
___ Quit, when_____
___ Less than daily
___ Daily
packs/day _____
years smoked____

Alcohol Use
___ Never ever
___ Quit, when_____
___ Less than 1 drink/day
___ 1-2 drinks/day
___ 3 or more drinks/day

Exercise Frequency
___ Never ever
___ Several times/day
___ Once a day
___ Few times/week
___ few times/month
___ other

Why are you being seen today? Include what, when, where, and who

On the job? Y N Auto accident? Y N Adjustor_____

Any other orthopedic problems?

Pharmacy: Name and location

Doctors: Name Location
Referring:

Primary:

Other docs: Name Location What are they treating?