Date: ___________________

Patient Name: ______________________________ ☐ Male ☐ Female Date of Birth: ______________

Primary Care Physician: ________________________ Who referred you: ________________________

Reason for today's visit: ***(Please complete one form per body part)*** ☐ Second Opinion

Affected side: ☐ Right ☐ Left

Body part: ☐ Lower Leg ☐ Ankle ☐ Foot ☐ Skin

Main complaint: ____

Briefly describe how it happened: ____

Is your complaint a result of an injury? ☐ Yes ☐ No Date of injury: ______________________

Work comp injury? ☐ Yes ☐ No If yes, are you currently working? ☐ Yes ☐ No

Current level of pain (0 - 10 Worse): ________ Pain at best (0 -10 Worse): ________ Pain at worst (0 - 10 Worse): ________

Length of problem: __________________________ Have you had this problem before? ☐ Yes ☐ No

Problem is: ☐ Improving ☐ Worsening ☐ Staying the same ☐ Recurring
☐ Intermittent ☐ Constant
☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching

Associated symptoms: ☐ Swelling ☐ Bruising ☐ Catching/locking ☐ Instability/giving away
☐ Warmth ☐ Numbness ☐ Weakness ☐ Loss of motion
☐ Night pain ☐ Radiating down leg

Aggravating factors: ☐ Walking ☐ Sitting ☐ Exercise ☐ Weight bearing
☐ Stairs ☐ Standing ☐ Running ☐ Wearing socks/shoes ☐ None

Alleviating factors: ☐ Rest ☐ Ice ☐ Heat ☐ Stretching/Exercise
☐ Physical Therapy ☐ Elevation ☐ Use of walker/cane ☐ Sitting
☐ Limited weight bearing ☐ None

Prior evaluation or treatment for current problem: ☐ None
☐ X-rays ☐ ER/Office visit ☐ Cast/Splint ☐ Physical Therapy
☐ MRI ☐ Injections ☐ Surgery

- **Flu shot** (this season): ☐ Yes (Date: _________________) ☐ No ☐ Declined
- **Pneumonia shot** (if over 65 or immunocompromised): ☐ Yes (Date: _________________) ☐ No

NEW INTAKE FORM

Past Medical History		Family History (Please list family member) ☐ None
☐ High blood pressure	☐ Kidney disease	☐ High blood pressure
☐ Diabetes If yes, do you use insulin? ______	☐ HIV or AIDS ☐ Hepatitis Type _____	☐ Diabetes
☐ Thyroid problems	☐ MRSA history	☐ Heart disease
☐ Heart disease ☐ Heart attack ☐ Pacemaker	☐ Anemia ☐ Bleeding problems	☐ Rheumatoid arthritis
☐ Cancer Type?______________________	☐ Rheumatoid arthritis	☐ Blood clots (DVT/pulmonary embolism)
☐ Blood clots (DVT/pulmonary embolism)	☐ Osteoporosis ☐ Osteoarthritis	☐ Bleeding problems
☐ Stroke ☐ Peripheral neuropathy	☐ Trouble with anesthesia	☐ Osteoporosis
☐ Rash/skin lesions		
☐ COPD		
☐ Reflux/GERD or ☐ Stomach ulcer		
☐ Gout		

Review of Systems				☐ None
Constitutional	☐ Fever	☐ Chills		
Cardiovascular	☐ Chest pain	☐ Fast heart rate	☐ Palpitations	
Respiratory	☐ Cough	☐ Sleep apnea and ☐ Use of CPAP	☐ Difficulty breathing	☐ Wheezing
Gastrointestinal	☐ Nausea/vomiting	☐ Heartburn/ulcers		
Musculoskeletal	☐ Joint stiffness	☐ Muscle aches	☐ Joint pain	☐ Muscle weakness
Skin	☐ Itching	☐ Skin lesion	☐ Skin rash	☐ Heat/cold intolerance
Psychiatric	☐ Depression/Anxiety	☐ Drug/alcohol addiction	☐ Sleep disorder	
Hematologic	☐ Easy bleeding	☐ Easy bruising	☐ Anemia	
Immunologic	☐ Hives	☐ Persistent infections		

List previous surgeries and dates: ☐ None

1. ______________________________ Date:______________
2. ______________________________ Date:______________

List current medications, dosages, and directions: ☐ None (please provide list if there are more than 4 medications)

1. ____________________ 3. ____________________
2. ____________________ 4. ____________________

List allergies and reactions: ☐ No known allergies

1. ____________________ 3. ____________________ ☐ **Latex** ☐ **Iodine**
2. ____________________ 4. ____________________ ☐ **Metal/Nickel**

Social History:

- Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
- Tobacco use: ☐ None ☐ Previous ☐ Current ________Amount/day
- Alcohol use: ☐ None ☐ Previous ☐ Current ________Amount/day
- Illegal drug use: ☐ None ☐ Previous ☐ Current If yes, what drug(s)? ____________________
- Physical Activity: How many days a week do you get moderate exercise? (e.g. Brisk walk) ______
  Duration: (e.g. Minutes) ______
- Are you currently **pregnant?**: ☐ Yes ☐ No

Signature:______________________ Print name:______________________ Date:______________

NEW INTAKE FORM