Patient Intake Form

Date: _____

□ Translator: _____ Language: _____

Reason for Visit: _____

Primary Physician: _____

Place Sticker

□ **Right Hip**
Began: □ <3mo □ 3-6mo □ ½-1y □ 1-5y □ >5y
Timing: □ Old □ New □ On/Off □ Constant
□ Now Worse
Quality: □ Stiff □ Sharp □ Stabbing □ Dull □ Achy
□ Throbbing □ Lightning □ Tingling □ Numb
□ Other: _____
Severity out of 10 (10 = worst pain ever): _____
Location: □ Groin □ Side □ Thigh □ Buttock
Travels to: □ Back □ Knee □ Foot
Worse with: □ Standing □ Sitting □ Lying Down
□ On/Off Shoes □ In/Out Car
□ Up/Down Chair □ Kneel/Squat
□ Up Stairs □ Down Stairs
□ Walking
□ Short Distances □ <5 blocks
□ <1 mile □ Cannot Walk at All
□ Exercise - Type: _____
□ Sleeping
Better with: □ Standing □ Sitting □ Lying Down
□ Rest □ Activity □ Medications

□ **Left Hip**
Began: □ <3mo □ 3-6mo □ ½-1y □ 1-5y □ >5y
Timing: □ Old □ New □ On/Off □ Constant
□ Now Worse
Quality: □ Stiff □ Sharp □ Stabbing □ Dull □ Achy
□ Throbbing □ Lightning □ Tingling □ Numb
□ Other: _____
Severity out of 10 (10 = worst pain ever): _____
Location: □ Groin □ Side □ Thigh □ Buttock
Travels to: □ Back □ Knee □ Foot
Worse with: □ Standing □ Sitting □ Lying Down
□ On/Off Shoes □ In/Out Car
□ Up/Down Chair □ Kneel/Squat
□ Up Stairs □ Down Stairs
□ Walking
□ Short Distances □ <5 blocks
□ <1 mile □ Cannot Walk at All
□ Exercise - Type: _____
□ Sleeping
Better with: □ Standing □ Sitting □ Lying Down
□ Rest □ Activity □ Medications

□ **Right Knee**
Began: □ <3mo □ 3-6mo □ ½-1y □ 1-5y □ >5y
Timing: □ Old □ New □ On/Off □ Constant
□ Now Worse
Quality: □ Stiff □ Sharp □ Stabbing □ Dull □ Achy
□ Throbbing □ Lightning □ Tingling □ Numb
□ Other: _____
Severity out of 10 (10 = worst pain ever): _____
Location: □ Front □ Deep □ Inside □ Outside
Travels to: □ Foot
Worse with: □ Standing □ Sitting □ Lying Down
□ On/Off Shoes □ In/Out Car
□ Up/Down Chair □ Kneel/Squat
□ Up Stairs □ Down Stairs
□ Walking
□ Short Distances □ <5 blocks
□ <1 mile □ Cannot Walk at All
□ Exercise - Type: _____
□ Sleeping
Better with: □ Standing □ Sitting □ Lying Down
□ Rest □ Activity □ Medications

□ **Left Knee**
Began: □ <3mo □ 3-6mo □ ½-1y □ 1-5y □ >5y
Timing: □ Old □ New □ On/Off □ Constant
□ Now Worse
Quality: □ Stiff □ Sharp □ Stabbing □ Dull □ Achy
□ Throbbing □ Lightning □ Tingling □ Numb
□ Other: _____
Severity out of 10 (10 = worst pain ever): _____
Location: □ Front □ Deep □ Inside □ Outside
Travels to: □ Foot
Worse with: □ Standing □ Sitting □ Lying Down
□ On/Off Shoes □ In/Out Car
□ Up/Down Chair □ Kneel/Squat
□ Up Stairs □ Down Stairs
□ Walking
□ Short Distances □ <5 blocks
□ <1 mile □ Cannot Walk at All
□ Exercise - Type: _____
□ Sleeping
Better with: □ Standing □ Sitting □ Lying Down
□ Rest □ Activity □ Medications

Please Share Any Details You Feel We May Have Missed:_____
_____
_

□ **Spine/Low Back**
Began: □ <3mo □ 3-6mo □ ½-1y □ 1-5y □ >5y
Timing: □ Old □ New □ On/Off □ Constant
□ Now Worse
Quality: □ Stiff □ Sharp □ Stabbing □ Dull
□ Achy □ Throbbing □ Lightning
□ Tingling □ Numb □ Other: _____
Severity out of 10 (10 = worst pain ever): _____
Location: □ Low Back □ Buttock
Travels to: □ Knee □ Foot
Worse with: □ Standing □ Sitting □ Lying Down
□ On/Off Shoes □ In/Out Car
□ Up/Down Chair □ Kneel/Squat
□ Up Stairs □ Down Stairs
□ Walking
□ Short Distances □ <5 blocks
□ <1 mile □ Cannot Walk at All
□ Exercise - Type: _____
□ Sleeping
Better with: □ Standing □ Sitting □ Lying Down
□ Rest □ Activity □ Medications

Please Share Any Details You Feel We May Have Missed:_____
_____
_

I have tried the following to treat my pain (place an 'X'), if it worked also 'Circle' it:

□ Ice □ Heat □ Weight Loss □ Physical Therapy □ Brace □ Cane □ Crutch(es) □ Walker □ Wheelchair
□ Tylenol/Acetomenophen □ Ultram/Tramadol
□ Anti-inflammatories: □ Ibuprofen/Motrin/Advil □ Aleve/Naproxen □ Celecoxib/Celebrex □ Other: _____
□ Herbals: □ Glucosamine/Chondroitin □ Other:_____
□ Narcotics: □ Norco □ Percocet □ Other:_____
□ Injections: □ Steroid/Cortisone □ Platelet-rich Plasma □ Autologous Stem Cells

□ Visco-supplementation (Synvisc, Orthovisc, Euflexxa, Hyalgan, or Supartz)
□ Surgery – Please list in Surgery Section to Follow
□ Other:_____

Are your Legs Equal in Length: □ Yes □ Right Longer □ Left Longer

Sitting: □ Any Chair □ High Chair □ Unable to Sit without Pain
Maximum Time Sitting: □ Unlimited □ over 1 hour □ less than 30 minutes

Walking Support outside you Home: □ None □ Cane □ Crutch(es) □ Walker □ Wheelchair
Walking Support in your Home: □ None □ Cane □ Crutch(es) □ Walker □ Wheelchair
Why Use Support: □ None □ for Hip Pain □ for Knee Pain □ for Limp □ for Balance
Maximum Walking Distance, Supported: □ None □ Indoors □ 1-3 Blocks □ Unlimited
Walking Distance, NO Support: □ None □ Indoors □ 1-3 Blocks □ Unlimited

Can you go up/down Stairs: □ No
□ Two Feet on Each Step
□ One Foot on Each Step with Railing
□ One Foot on Each Step without Railing

Your Highest Level of Activity:
□ Heavy Labor/Vigorous Sports (High Impact)
□ Moderate Labor/Sports (Lifting, Running)
□ Light Labor/Sports (House Cleaning, Yard Work)
□ Partially Sedentary (Housework, Desk Work)
□ Sedentary (Minimal Activity)
□ Bedridden or Wheelchair Bound

Please Share Any Details You Feel We May Have Missed:_____
_____

General Medical Review (Have you had any of these issues?)

General Health

□ Anxiety
□ Hypothyroidism
□ Depression/Bipolar
□ Parkinson's Disease
□ Delirium/Dementia
□ Addiction
□ Stroke
□ Seizures
□ Cancer
□ Headaches
□ Change in Weight
□ Change in Appetite
□ Fatigue
□ Change in Sleep
□ Mouth Sores
□ Loss of Memory
□ Incontinence

Muscle/Skin/Bone

□ Varicose Veins
□ Psoriasis
□ Radiation Exposure
□ Gout
□ Osteoporosis
□ Recurrent Rash
□ Non-healing Ulcer

Respiratory

□ Asthma
□ COPD/Emphysema
□ Sleep Apnea
□ Pulmonary Embolism
□ Wheezing
□ Short of Breath
□ Cough

Heart

Stomach/Intestines

Blood/Immunity

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Atrial Fibrillation
- ☐ Irregular Beat
- ☐ Pacer/Defibrillator
- ☐ Heart Attack
- ☐ Stent Placement
- ☐ Heart Failure
- ☐ Passing Out
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swelling
- ☐ Gastric Reflux
- ☐ Stomach Ulceration
- ☐ Hepatitis
- ☐ Kidney Failure
- ☐ Dialysis
- ☐ Diabetes:
  - ☐ Insulin
  - ☐ Non-Insulin
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Vomiting
- ☐ Yellowing Skin/Eyes
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Anemia
- ☐ Prior Blood Clot
- ☐ Hemophilia
- ☐ Multiple Infections
- ☐ Rheumatoid Arthritis
- ☐ Autoimmune Disorder
- ☐ Fever/Sweats
- ☐ Easy Bruising
- ☐ Bleeding
  Location:_____

Please Specify or Clarify Any Medical Issue(s):_____

_____

Past Surgeries (list all prior surgeries, including those on your joints)

Type of Surgery	Location	Year	Surgeon	Hospital

Prescription, Herbal, and Over-the-Counter Medications ☐ List Attached

Medication	Dose	Frequency	Reason

Allergic Reactions ☐ List Attached

Medication/Item	Reaction

Medical Problems that Run in Your Family (Mother, Father, Siblings, Children)

Family Member	Age	Deceased (Y/N)	Medical Issue(s)

Personal Demographics
Birthplace (City and Country): _____

Racial Background: ☐ Caucasian ☐ Hispanic ☐ Asian/Pacific Islander ☐ Black/African American
☐ American Indian/Alaskan Native ☐ Multiracial ☐ Other: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Occupation: ☐ Employed Full-time ☐ Employed Part-time ☐ Student ☐ Homemaker ☐ Retired
☐ Unemployed ☐ Disabled

List Current Occupation and Position/Title: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Number of Children:_____

Living Situation: ☐ Live Alone ☐ Live with Spouse/Relatives ☐ Nursing/Care Facility

Alcohol Use: ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially
Began Using: _____ Drinks/Week: _____ Year Quit: _____

Smoking/Tobacco Use: ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially
Began Using: _____ Packs/Day: _____ Year Quit: _____

Illicit Drug Use: ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially
☐ Marijuana ☐ Cocaine ☐ Heroine ☐ Methamphetamine
Began Using: _____ Year Quit: _____