UPDATED INTAKE FORM

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ SSN: _____

Phone (Home): _____ Phone (Cell) :_____

Employer: _____ Phone (work): _____

Email: _____Marital Status: ____Sex: M___F___Other___

Emergency Contact: _____ Relationship:_____

Emergency Contact Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

IF YOUR INSURANCE HAS CHANGED, PLEASE COMPLETE THE FOLLOWING:

CURRENT INSURANCE COMPANY: _____

POLICY# _____ POLICY HOLDER: _____

REASON FOR TODAYS VISIT _____

IS TODAYS VISIT RELATED TO AN AUTO ACCIDENT? YES/NO _____

IS TODAYS VISIT RELATED TO WORK/PERSONAL INJURY? YES/NO _____

*(IF YOU ANSWERED **YES** TO ANY OF THE ABOVE QUESTIONS):*

TYPE OF ACCIDENT? WORK_____ AUTO _____ PERSONAL _____

Date of Accident? _____ Claim# _____

Car Insurance Company: _____Policy #:_____

Adjuster: _____ Adjusters Phone Number: _____

If Workers Comp, List Workers Comp Carrier: _____

UPDATED MEDICAL HISTORY FORM – TOTAL REHABILITATION & SPORTS MEDICINE

PATIENT NAME: _____ **PATIENT DOB:** _____/_____/_____

Describe the reason for your visit:

_____

_____

_____

_____

How long have you had this problem? _____

_____

Previous Hospitalizations/Surgeries/Serious Injuries: **Month/Year:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Patient Social History (Circle One):

Marital Status:

Single Married Separated Divorced Widowed

Use of Alcohol:

Never Rarely Moderate Daily

Use of Tobacco:

Never Previously, but quit Current: Packs/Day _____

Use of Drugs:

Never Type/Frequency: _____

Family Medical History:

	Age	Diseases
Father:	_____	_____
Mother:	_____	_____
Siblings:	_____	_____
	_____	_____
Children:	_____	_____
	_____	_____

Additional Comments/Concerns: _____

_____

Current Height: _____ **Current Weight:** _____

PATIENT SIGNATURE: _____

Have you ever had the following?

Diabetes	Yes	No
Hypertension	Yes	No
Cancer	Yes	No
Stroke	Yes	No
Heart Disease	Yes	No
Arthritis/Gout	Yes	No
Seizure Disorders	Yes	No
Bleeding Tendency	Yes	No
Acute Infections	Yes	No
Endocrine Disease	Yes	No
Asthma	Yes	No

List medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Are you allergic to any foods, medications, or any other substances ..... Yes No

If yes, please list:

1. _____
2. _____
3. _____
4. _____
5. _____

TODAY'S DATE: _____/_____/_____

MEDICAL HISTORY UPDATE

PLEASE ANSWER ALL QUESTIONS

Are you **currently** experiencing any of the following?

CONSTITUTIONAL

Good general health lately.....	NO	YES
Recent weight gain.....	NO	YES
Fever.....	NO	YES
Fatigue.....	NO	YES
Headaches.....	NO	YES

EYES

Eye disease or injury.....	NO	YES
Wear glasses or contact lenses.....	NO	YES
Glaucoma.....	NO	YES
Blurred vision or Double vision.....	NO	YES

ENT

Hearing loss.....	NO	YES
Ringing in ears.....	NO	YES
Earaches or drainage.....	NO	YES
Sinus problems.....	NO	YES
Nose bleeds.....	NO	YES
Mouth Sores.....	NO	YES
Bleeding gums.....	NO	YES
Bad breath or bad taste in mouth...	NO	YES
Sore throat or voice change.....	NO	YES
Swollen glands.....	NO	YES

CARDIOVASCULAR

Heart Trouble.....	NO	YES
Chest pain.....	NO	YES
Sudden heartbeat changes.....	NO	YES
Swelling of feet, ankles or hands....	NO	YES

MUSCULOSKELEKAL

Joint pain	NO	YES
Join Stiffness or swelling	NO	YES
Weakness of muscles or joints.....	NO	YES
Back pain.....	NO	YES
Cold extremities.....	NO	YES
Difficulty in walking.....	NO	YES

SKIN

Rash or itching.....	NO	YES
Change in skin color.....	NO	YES
Change in hair or nails.....	NO	YES
Varicose veins.....	NO	YES
Breast pain.....	NO	YES
Breast lump.....	NO	YES
Breast discharge.....	NO	YES

NEUROLOGICAL

Frequent or recurring headaches.....	NO	YES
Lightheaded or dizzy.....	NO	YES
Convulsions or seizures.....	NO	YES
Numbness or tingling sensations.....	NO	YES
Tremors.....	NO	YES
Paralysis.....	NO	YES
Stroke.....	NO	YES
Head injury.....	NO	YES

PSYCHIATRIC

Memory Loss or confusion.....	NO	YES
Nervousness.....	NO	YES
Depression.....	NO	YES
Sleep Problems.....	NO	YES

RESPIRATORY

Frequent Coughing..... NO YES

Spitting up blood..... NO YES

Shortness of breath..... NO YES

Asthma or wheezing..... NO YES

GASTROINTESTINAL

Loss of appetite..... NO YES

Change in bowel movements..... NO YES

Nausea or vomiting..... NO YES

Frequent Diarrhea..... NO YES

Painful bowel movements/constipation NO YES

Blood in stool..... NO YES

Stomach pain..... NO YES

GENITOURINARY

Frequent Urination..... NO YES

Burning or Painful Urination..... NO YES

Blood in urine..... NO YES

Change of force or strain when urinating NO YES

Incontinence or dribbling..... NO YES

Kidney stones..... NO YES

Sexual difficulties..... NO YES

Male – Testicular pain..... NO YES

Female- painful periods..... NO YES

Irregular periods..... NO YES

Vaginal discharge..... NO YES

# of Pregnancies _____

# of miscarriages_____

Date of last PAP smear _____ Normal _____ Abnormal_____

ENDOCRINE

Diabetes..... NO YES

Thyroid Disease..... NO YES

Glandular or hormone problems..... NO YES

Heat or cold intolerance..... NO YES

Excessive thirst or urination..... NO YES

Dry Skin..... NO YES

HEMOTOLOGICA/LYMPHATIC

Anemia..... NO YES

Slow to heal after cuts..... NO YES

Easily bruise or Bleed..... NO YES

Phlebitis..... NO YES

Past transfusions..... NO YES

Enlarged glands..... NO YES

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics..... NO YES

Morphine, Demerol or other narcotics... NO YES

Novocain or other anesthetics..... NO YES

Tetanus antitoxin or other serums..... NO YES

Iodine, Merthiolate or other antiseptic..... NO YES

Known Food Allergies..... NO YES

Seasonal Alergies..... NO YES

OTHER (anything else you want the doctor to be aware of)

_____

_____

PATIENT SIGN HERE: _____ DATE: _____