NEW PATIENT INTAKE

Name:____ Date:____

Address:____ Employer:____

City/State/Zip:____ Occupation:____

Home Ph:_____________________Work:_________________ Address:____

Cell Ph:______________________ SS#___________________ City/State/Zip:____

E-Mail:____ Insurance Co:____

Sex: M/F Birthdate:______________________ Age:_______ Policy Holder:____

Marital Status S/M/D/W Policy Holder SS#:_____________________________________

How did you hear about us?_____________________________ Policy Holder Birthdate:_________________________________

Who may we thank for referring you? ____________________ Policy Holder Employer: ________________________________

Family Physician:_______________________________________ Policy Holder Employer Address : ________________________

Emergency Contact and Phone #: ________________________

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1. Chief Complaint:____ When did it start?____

How did the complaint begin(mechanism of injury)?____

Please Circle the quality of the complaint/pain: Dull Aching Sharp Stabbing Radiating Sore Burning Throbbing Deep Nagging

Does the pain radiates or shoots to any part of the body? Where?____

Severity of Complaint(1-10) with 0 being no pain/symptoms and 10 the worst pain imaginable: 0 1 2 3 4 5 6 7 8 9 10

Please Circle the frequency: Occasional(0-25% of day) Intermittent(25-50% of day) Frequent(50-75% of day) Constant(75-100% of day)

What makes the pain worse?____ What makes it better?____________________________________

2. Second Complaint:(Skip if not relevant)____________________________ When did it start?____

How did the complaint begin(mechanism of injury)?____

Please Circle the quality of the complaint/pain: Dull Aching Sharp Stabbing Radiating Sore Burning Throbbing Deep Nagging

Does the pain radiates or shoots to any part of the body? Where?____

Severity of Complaint(1-10) with 0 being no pain/symptoms and 10 the worst pain imaginable: 0 1 2 3 4 5 6 7 8 9 10

Please Circle the frequency: Occasional(0-25% of day) Intermittent(25-50% of day) Frequent(50-75% of day) Constant(75-100% of day)

What makes the pain worse?____ What makes it better?____________________________________

3. Third Complaint:(Skip if not relevant)_______________________________ When did it start?____

How did the complaint begin(mechanism of injury)?____

Please Circle the quality of the complaint/pain: Dull Aching Sharp Stabbing Radiating Sore Burning Throbbing Deep Nagging

Does the pain radiates or shoots to any part of the body? Where?____

Severity of Complaint(1-10) with 0 being no pain/symptoms and 10 the worst pain imaginable: 0 1 2 3 4 5 6 7 8 9 10

Please Circle the frequency: Occasional(0-25% of day) Intermittent(25-50% of day) Frequent(50-75% of day) Constant(75-100% of day)

What makes the pain worse?____ What makes it better?____________________________________

4. **Previous treatments you have had for your current condition**:______________________________

5. **Past Medical History:**

A. Major Illnesses:______________________________

B. Previous Injury or Trauma:______________________________

C. Have you ever broken any bones? Which?______________________________

D. Allergies:______________________________

E. Current Medications:____________________ Reason for Taking:____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

F. Previous Surgeries:____________________ Year__________ Surgeon:__________

____________________ Year__________ Surgeon:__________

____________________ Year__________ Surgeon:__________

____________________ Year__________ Surgeon:__________

6. **Family Health History:**

Associated Health Problems of Relatives:______________________________

____

Deaths in immediate family:

Cause of parents or siblings death	Age at Death
____________________	____________________
____________________	____________________
____________________	____________________

7. **Social and Occupational History:**

A. Job Description:______________________________

B. Recreational Activities(Interests):______________________________

C. Lifestyle(level of exercise, alcohol, tobacco usage)

Cigarettes: ☐ Yes ☐ No Alcohol: ☐ Yes ☐ No If Yes, how much:____________________

Exercise Regularly: ☐ Yes ☐ No If Yes, State frequency:____________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to perform any necessary examinations and/or treatment in accordance with Texas statutes and laws.

Patient Signature______________________________ Date____________________

Guardian Signature______________________________ Date____________________