OrthoArizona

PATIENT INTAKE

Patient name: *(First, Last)* ____

Occupation: _________________________

Height: ____**ft** _____**in** **Weight:** ______ **lbs** **Hand dominance:** LEFT / RIGHT / AMBIDEXTROUS

Do you have diabetes? YES / NO **If "Yes", type** _____

Any recent falls? YES / NO **If "Yes", were you injured?** YES / NO

Did you have a flu shot in past year? YES / NO

Did you have a Pneumonia vaccination? YES / NO **If "Yes", when**_________

INJURY / PAIN / CONCERN - INFORMATION

Body part: _______________________________ **Side of the body affected:** LEFT / RIGHT / BOTH

Reason for visit:____

When did the problem start / date of injury? ________ ____ ______
month day year

How did it happen?____

What makes it better? ____

What makes it worse? ____

Pain frequency: RARE / SOMETIMES / ALWAYS

Pain scale: *(circle)* 1 (mild) 2 3 4 5 (moderate) 6 7 8 9 10 (severe)

Received previous treatment for this problem? YES / NO **If "Yes", Provider:**___________________ **Month/Year:**_________

Circle any type of images or tests you've had for this problem? X-RAYS / CAT SCAN (CT)/ MRI / EMG / LAB WORK / ULTRASOUND

If you had images or tests, which location / facility / company did them:____

Current treatment of problem: BRACING / CANE / CRUTCHES / WALKER / INJECTION / MEDICATION / SURGERY / THERAPY / NONE

Pain description: ACHY / BURNING / DULL / SHARP / THROBBING / OTHER__________________________________

Associated symptoms: CATCHING / POPPING / LOCKING / GRINDING / SWELLING / STIFFNESS / INSTABILITY / WEAKNESS / TINGLING / NIGHT PAIN / OTHER__________________

List any medications or supplements you are currently taking:
*** if taking more than below, ask the front desk for the medication form*

MEDICATION / SUPPLEMENT	DOSE

List any allergies you may have (medications, food, latex, iodine, nuts, etc) and the reaction to each:

ALLERGIC TO:	REACTION

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