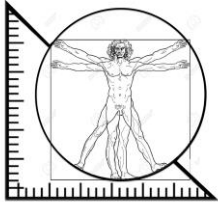

Bay Area Orthopedic Institute

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INITIAL CONSULT INTAKE FORM

Full Name_______________________________ Today's Date ___________

Age______ **Right** or **Left** Handed? Job Title: ___________________________________

Describe typical work duties: ____

What part of the body is injured? ____
How bad would you rate your pain at rest? (1 is lowest, 10 is highest) ______
How bad would you rate your pain at its worst? (1 is lowest, 10 is highest) ______
How bad would you rate your pain currently? (1 is lowest, 10 is highest) ______

Briefly describe how injury occurred:
____

____

____

Describe your pain (circle all that apply or write a word to describe in the blank space):

"cramping" "shooting" "ache" "dull" "sharp" "constant" "off and on" _________________

What makes it worse? ____

What makes it better? ____

WHERE were you treated before coming here? ____

WHAT doctor sent you here? ____

Have you had: (please circle) **MRI** **X-Ray** **EMG** **Physical Therapy** **Surgery**

Acupuncture **Steroid injection** **Chiropractic**

Have you ever injured the same body part in the past? **Yes** **No** (If NO, move to next question)
If YES, was injury work related? **Yes** **No** If YES, Date of injury: _____/_____/______
Are you currently working? **Yes** **No**

Past Medical History:

High blood pressure	Cholesterol	Diabetes	Heart Disease
Thyroid problems	Reflux	Osteoporosis	Cancer

Other: ____

Any prior Surgeries? ____

Anyone in your family have a disease? (i.e. a brother with diabetes, a mom with breast cancer, etc.)

____

____

Do you smoke? **Yes** **No** Drink alcohol? **Yes** **No** Drug usage? **Yes** **No**

List **ALL** medicines that you take routinely: ____

____

Any Allergies to medicine? **Yes** **No** If YES, List them: ____________________________________

Do you have any of the following?

Constant Fevers/Chills?	**Yes**	**No**
Dramatic/Unintended weight loss?	**Yes**	**No**
Severe/Constant headaches?	**Yes**	**No**
Excessive thirst?	**Yes**	**No**
Excessive hunger?	**Yes**	**No**
Cataracts?	**Yes**	**No**
Hearing loss?	**Yes**	**No**
Frequent nose bleeds?	**Yes**	**No**
Thyroid enlargement?	**Yes**	**No**
Chest Pain?	**Yes**	**No**
Abnormal or racing heart beat?	**Yes**	**No**
Shortness of breath with normal activity?	**Yes**	**No**
Chronic cough?	**Yes**	**No**
Constant Nausea/Vomiting?	**Yes**	**No**
Frequent abdominal pain?	**Yes**	**No**
Loss of bowel/bladder control?	**Yes**	**No**
Blood in your stools?	**Yes**	**No**
Painful urination?	**Yes**	**No**
Intolerance to heat or cold?	**Yes**	**No**
Excessive anxiety or nervousness?	**Yes**	**No**
Easy bruising or bleeding?	**Yes**	**No**