RETURNING PATIENT INTAKE

Patient's Name: Date of Birth:

Date of Visit: Location of Care:

Please take a few minutes to fill out this medical intake to facilitate your appointment today.

About Your Pain:

Chief Complaint:____

Where are you feeling pain today? ____

Describe your pain (aching, burning, cramping, etc.):_____________________________

Is the pain constant? ☐ Yes | ☐ No | ☐ N/A How long have you had the pain?__________________

Rate your pain: No Pain- 1 2 3 4 5 6 7 8 9 10- Worst Pain

Rate your pain with meds: 1 2 3 4 5 6 7 8 9 10

What makes you pain worse?_________________________Better?___________________________

What medication are you taking for pain?_______________________________________

How are you taking your pain medication?_______________________________________

Are you taking medication NOT managed by this office? ☐ Yes | ☐ No Please List:____________________

Do you have any allergies? Please list:__________________________

Has COMFORT improved with pain medication? ☐ Yes | ☐ No

Has FUNCTION improved with pain medication? ☐ Yes | ☐ No

Are you more able to care for yourself? ☐ Yes | ☐ No

Are you more able to work? ☐ Yes | ☐ No

Are you more able to care for your family? ☐ Yes | ☐ No

Date of last procedure:___________Results:________________

Any new testing, imaging, doctor visits, or hospitals visits?______________

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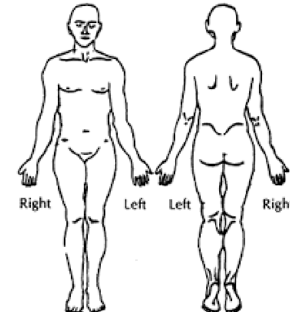

Please shade where it hurts.

Medical History

Have you ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other____________________________

Have you ever had surgery? ☐ Back Surgery | ☐ Neck Surgery

Are you a smoker? ☐ Yes | ☐ No

Are you employed? ☐ Yes | ☐ No

Review of Systems

Are you having any gastrointestinal symptoms? ☐ Constipation | ☐ Nausea | ☐ Other | ☐ None

Are you having any psychological symptoms? ☐ Depression| ☐ Sleep Disturbance | ☐ Other | ☐ None

Any neurological symptoms? ☐ Loss of Bladder/ Bowel Control| ☐ Weakness | ☐ Other | ☐ None

Any other symptoms?____

Patient Signature: **Employee's Initials:** **Provider's Initials:**