INTAKE FORM Date:_____

Name:_____ **DOB:**_____ **Ht:**____'____" **Wt:**_____lbs

INJURY/ ILLNESS INFORMATION

Referring Dr:_____

◆ Which of the following best describes how your medical problem began: (check only ONE)

☐ Work Related ☐ Auto Accident ☐ Accident at Home ☐ Began spontaneously ☐ Sports Injury

◆ Please tell us how your medical problem began (**DATE** & how it happened):

_____

_____

_____

◆ Which body parts are affected (indicate **Rt** OR **Lt**)? _____

◆ Please indicate treatment you have received for this injury:

☐ Physical Therapy (Where at & for how long?_____)

☐ E.R. or Urgent Care (Which location? _____) ☐ None

☐ Other: _____

◆ Rate your pain on a scale of 1-10 (10 being **extremely** severe/worst pain you've ever had)_____

◆ Characterize your symptoms: ☐ Aching ☐ Sharp ☐ Burning ☐ Stabbing ☐ Cramping

☐ Intermittent ☐ Constant ☐ Dull ☐ Throbbing ☐Other:_____

◆ Symptoms **improve** with: ☐ Rest ☐ Activity ☐ Ice ☐ Heat ☐ Medication

◆ Symptoms feel **worse** with: ☐ Rest ☐ Activity ☐ Ice ☐ Heat ☐ Other: _____

◆ Since the onset are your symptoms: ☐ Improved ☐ Worsened ☐ Unchanged

MEDICAL HISTORY (Please list **ALL** medical history/illnesses you have had or currently have)

☐Anemia	☐Diabetes	☐Liver dis./Hepatitis	☐Stomach Ulcers
☐Asthma	☐Elev. Cholesterol	☐Obesity	☐Stroke/TIA/CVA
☐Bleeding Disorder	☐Angina/Arrhythmia	☐Osteoarthritis	☐Thyroid Disease
☐Blood Transfusions	☐Fibromyalgia	☐Osteoporosis	☐Other_____
☐BPH/Prostate dis.	☐ GERD	☐Osteomyelitis	_____
☐Bronchitis	☐ Glaucoma	☐Peripheral Vascular	_____
☐Cancer	☐Gout	☐Phlebitis	_____
☐COPD	☐Hypertension	☐Rheumatoid Arthritis	_____
☐Coronary Artery dis.	☐Intestinal Disease	☐Seizures	_____
☐Depression	☐Kidney/Renal Dis.		☐None

Name: _____ Date:_____

SURGICAL HISTORY (Please list **ALL** surgeries you have had)

☐Arthroscopy Knee	☐Carpal Tunnel Release	☐Hysterectomy	☐Other: _____
☐Arthroscopy Shoulder	☐Back Surgery	☐Hernia	_____
☐Total Hip Replcmt	☐Neck Surgery	☐Bowel Surgery	_____
☐Total Knee Replcmt	☐Appendectomy	☐Tonsillectomy	_____
☐Rotator Cuff Repair	☐Gall Bladder	☐C-Section	_____

FAMILY/ SOCIAL HISTORY

◆ Father: ☐ Living ☐ Deceased - Medical Conditions: _____

_____

◆ Mother: ☐ Living ☐ Deceased - Medical Conditions: _____

_____

◆ Siblings: ☐ All Living ☐ Some Living/Some Deceased ☐ All Deceased ☐ Unknown

- Medical Conditions: _____

◆ Marital Status: _____ ◆ Do you drink caffeinated beverages? **YES / NO**

◆ Do you drink alcohol? : ☐ Never ☐ Very Rarely ☐ Rarely ☐ Socially ☐ Daily

◆ Do you use tobacco? _____ ◆ If so, what kind & how much per day? _____

MEDICATIONS [Please list **ALL** medications you are currently taking (Rx and Over-the-counter)]

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES (Please list **ALL** allergies you have, and the reaction to each)

_____

_____

◆ By signing below, I certify the above information provided is accurate and correct to the best of my knowledge. I will notify Dr. Greendyke or his staff if there are any changes to the above.

Signature _____Date_____