Center for Musculoskeletal Care

New Patient Intake Form

HISTORY FORM TODAY'S DATE:

Name: _____Date of Birth:_____/_____/_____Age:_____Male:_____Female:_____

Address:_____City:_____State:_____Zip:_____

Cell Phone#: _____Home Phone_____Email:_____

PLEASE DESCRIBE YOUR MAIN REASON FOR THIS APPOINTMENT

Is the reason for your visit related to: _____Auto accident _____Work Injury _____Neither

Briefly describe your symptoms: _____

_____

When did your symptoms begin?_____

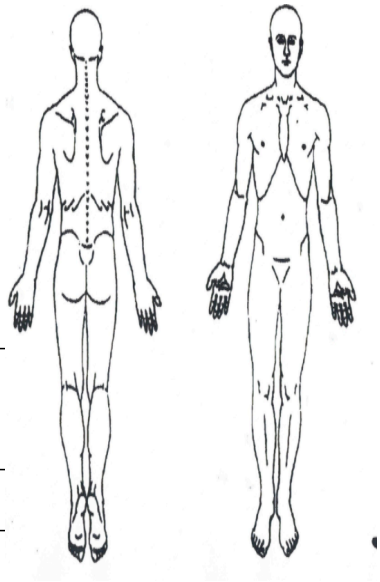
Is your condition getting worse? _____Yes _____ No

Have you had this condition in the past? _____ Yes _____ No

Is your discomfort: ____ Constant ____ Frequent ____ Occasional ____ Intermittent

Have you seen other doctors for these conditions? ____Yes ____ No

(If yes please list) _____



Please mark areas of pain on the figures

What helps relieve your symptoms? _____

_____

What activities aggravate your condition? _____

How much have your symptoms interfered with your daily activities (circle a number)

no effect 0 1 2 3 4 5 6 7 8 9 10 no possible activities

Rate your average pain intensity from your primary symptom.

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Describe the nature of your symptoms: ___ Sharp ____ Dull ___ Numb ___ Burning ____ Shooting ___ Tingling

___ Stabbing ___ Throbbing ___ Radiating ___Tightness ___ Other

Have you experienced any accident or falls in the past: ____ Year _____5 Years _____ Never

In general, would you say your overall health right now is : ___Excellent ____ Very good ____ Good ____Fair ____Poor

How does this condition interfere with your life and ability to function? _____

_____