Physical Medicine & Rehabilitation
Intake Form

Name: ____________________________ Age: ______ Date: ____________

PAIN DIAGRAM. Mark the areas on your body where you now feel your typical pain. Include all areas.
Use the following symbols below. (If you have no pain skip to next page.)

- Pain XXXXXX
- Numbness OOOOOO
- Pins and needles ///////////

Put a large X over the spot that you have the most pain

FRONT SIDE

PLEASE CIRCLE ALL THAT APPLY:
- How long have you had your pain? _____ Weeks _____ Months _____ Years
- How often do you have your pain? Constant Comes and goes
- What caused the onset of pain? Work Auto accident Lifting Twisting Fall Sports Other Unknown
- Pain progression? Better Worse Unchanged
- Quality of pain? Stabbing Shooting Aching Burning Cramping Sharp Dull None Other ________________

How severe is your pain at worst? (0=no pain, 10=worst pain imaginable)

1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

What makes the pain worse?

What makes the pain better?

Have you had any of the following? (please circle)

MRI CT scan Bone scan X-rays Nerve testing (EMG) None Other ________________

Massage PT Chiropractor Acupuncture Injections Meds None Other ________________

Consult with a medical/surgical specialist ________________
REVIEW OF SYSTEMS. Mark any of the following symptoms that you have had during the past year.

CONSTITUTIONAL SYMPTOMS
___Recent weight change
___Fever or chills
___Night sweats
___Lack of energy or fatigue
___none of the above

EYES
___Eye pain or redness
___Loss of vision
___Blurred vision or double vision
___none of the above

EARS/NOSE/MOUTH/THROAT
___Hearing loss
___Ringing in ears
___Nose bleeds
___Difficulty swallowing
___Hoarseness
___none of the above

CARDIOVASCULAR
___Chest pain
___Abnormal heartbeat
___Shortness of breath with activity
___Shortness of breath when lying flat
___Swelling of feet or ankles
___none of the above

RESPIRATORY
___Chronic or frequent coughs
___Coughing up blood
___Breathing problems
___none of the above

GENITOURINARY
___Bloody urine
___Urgency of urination
___Frequency of urination
___Painful or difficult urination
___Dribbling or incontinence of urine
___Numbness over groin, genitalia or buttocks
___Sexual difficulties
___none of the above

MUSCULOSKELETAL
___Joint pain, stiffness, or swelling
___Muscle pain or cramps
___Increased pain with laying flat
___none of the above

SKIN/BREAST
___Rash
___Skin sores or ulcers
___Breast pain, lump or discharge
___none of the above

STOMACH AND INTESTINES
___Frequent nausea or vomiting
___Bloody vomiting
___Abdominal pain
___Recurring diarrhea
___Blood in stools
___Frequent or severe constipation
___none of the above

NEUROLOGICAL
___Headaches
___Light headedness or dizziness
___Convulsions or seizures
___Numbness or tingling in arms or legs
___Weakness in arms or legs
___Frequent falls
___none of the above

PSYCHIATRIC
___Difficulty sleeping
___Loss of appetite
___Memory loss or confusion
___Nervousness or anxiety
___Stress
___Depression
___none of the above

ENDOCRINE
___Easy bleeding or bruising
___Swollen glands or lumps in neck, armpits or groin
___none of the above

ALLERGIC/IMMUNOLOGIC
History of allergic reaction to:
___Penicillin or other antibiotics
___Morphine, Demerol, or other narcotics
___Vaccines or anesthetics
___none of the above

OTHER (please list any other symptoms)
PAST MEDICAL HISTORY. Mark any condition that you have had.

___High blood pressure ___High cholesterol ___Abnormal heart rhythm ___Heart disease ___Asthma ___Emphysema ___Pneumonia ___Tuberculosis ___Migraine headaches ___Seizures ___Head injury ___Stroke or TIA ___Depression ___Fibromyalgia ___Drug or alcohol addiction ___Diabetes ___Thyroid problems ___Osteoporosis ___Broken bones ___Arthritis or Gout ___Reflux or GERD ___Irritable bowel syndrome ___Stomach/duodenal ulcer ___Gallbladder disease ___Liver disease ___Polio ___Cancer ___Chronic use of Prednisone ___IV drug use ___HIV infection ___None of the above

Please list any other illnesses, hospitalizations, injuries, or operations.

ALLERGIES. List all allergies to medications.

MEDICATIONS. List your current medications with dosages.

CURRENT MEDICAL ISSUES. List any other current medical problems.

FAMILY MEDICAL HISTORY. List any illnesses that run in the family.
(Example: diabetes, cancer, stroke, heart problems, muscle problems, nerve problems, depression, alcoholism, etc.)