Return Patient Intake

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PATIENT NAME: ______________________________

Sex: ☐ M ☐ F

Date of Birth: _____/_____/________ Age: ______________

WORKER'S COMPENSATION PATIENTS ONLY:

Is this issue covered by workers' comp? ☐ YES ☐ NO

Are you coming in for a new work-related injury? ☐ YES ☐ NO

Who is your primary treating physician? ______________________________

Is your insurance or employer specifically requesting this exam for employment or medical disability purposes? ☐ YES ☐ NO

Are all of the symptoms you want to discuss today from the work-related injury? ☐ YES ☐ NO

RETURNING PATIENTS ONLY:

Was the last time you saw this doctor more than 3 years ago? ☐ YES ☐ NO

Do you have a new concern or symptom you'd like to discuss with the provider? ☐ YES ☐ NO

Are you returning to review MRI imaging or discuss surgery? ☐ REVIEW MRI ☐ SURGERY

How would you describe your symptom progress? ☐ IMPROVING ☐ UNCHANGED ☐ WORSENING

POST-OPERATIVE PATIENTS ONLY:

What surgery did you undergo? ______________________ When: ______________

Any recent fevers or chills? ☐ YES ☐ NO Any narcotic pain meds in the last 48 hours? ☐ YES ☐ NO

Are you seeking care for a new concern unrelated to your surgery today? ☐ YES ☐ NO

How would you describe results from surgery? ☐ SATISFIED ☐ UNSURE ☐ DISSATISFIED

ALL PATIENTS:

1) Which body part is **most affected**?

Which side? ☐ RIGHT ☐ LEFT ☐ BOTH Specifically? ☐ FRONT ☐ BACK ☐ INSIDE ☐ OUTSIDE

Which area? ☐ KNEE ☐ HIP ☐ THIGH ☐ CALF ☐ ANKLE ☐ FOOT ☐ TOE(S): __________ ☐ BACK
☐ SHOULDER ☐ ARM ☐ HAND ☐ WRIST ☐ FINGER(S): __________ ☐ OTHER: __________

2) Have you had a recent **re-injury** to this area? ☐ YES ☐ NO

If yes, how: ☐ SPORTS INJURY ☐ FALL ☐ CAR ACCIDENT ☐ OVERUSE ☐ WORK ☐ OTHER

If yes, when? ______________ Please describe: ______________________________

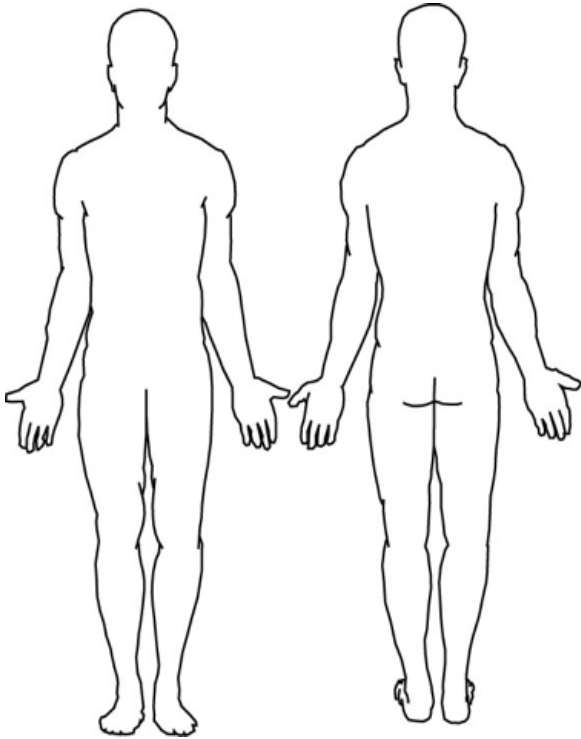
3) How likely do you think your symptoms will **require surgery**?

☐ I JUST HAD SURGERY ☐ VERY UNLIKELY ☐ UNLIKELY ☐ UNSURE ☐ LIKELY ☐ VERY LIKELY

4) What **diagnoses** have your recieved for these symptoms, if any? ______________________________

SYMPTOMS

Draw the appropriate symbols in the areas you want to discuss on the diagram below:



XXXXX for **PAIN** ☐ NONE

If you have **pain**, how would you describe its:

Timing	☐ CONSTANT	☐ INTERMITTENT	☐ WITH ACTIVITY
Quality	☐ ACHING	☐ STABBING	☐ DULL
Severity	☐ MILD	☐ MODERATE	☐ SEVERE

Scale (NO PAIN) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (WORST)

△△△△△ for **NUMBNESS/TINGLING** ☐ NONE

If you have **numbness or tingling**, describe its:

Timing	☐ CONSTANT	☐ INTERMITTENT	☐ WITH ACTIVITY
Severity	☐ MILD	☐ MODERATE	☐ SEVERE

○○○○○ for **SWELLING** ☐ NONE

If you have **swelling**, how would you describe its:

Timing	☐ CONSTANT	☐ INTERMITTENT	☐ WITH ACTIVITY
Severity	☐ MILD	☐ MODERATE	☐ SEVERE

5) Are you experiencing any of these additional **symptoms**?

☐ LIMITED MOTION ☐ WEAKNESS ☐ POPPING/LOCKING ☐ INSTABILITY ☐ ____________________

6) How are your symptoms affecting your ability to **work**?

☐ NO EFFECT ☐ LIMITED DUTY ☐ UNABLE TO WORK DETAILS: ____________________

7) What makes your symptoms **worse**?

☐ STANDING ☐ WALKING ☐ LIFTING ☐ SITTING ☐ STAIRS ☐ GRASPING ☐ ____________________

8) Are you experiencing any **difficulty with activities** you like to do?

☐ SLEEPING ☐ EXERCISING ☐ PLAYING SPORTS ☐ More: ____________________

TREATMENTS	**Did it provide relief?**	**Are you still using this?**
☐ Rest ☐ Ice ☐ Heat ☐ Brace ☐ Elevation	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED
☐ Avoiding activities: ____________	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED
☐ Oral anti-inflammatories: ☐ CELEBREX ☐ IBUPROFEN ☐ ASPIRIN ☐ NAPROXEN	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED
☐ Topical anti-inflammatories: ____________	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED
☐ Physical therapy sessions: #____________	☐ NONE ☐ SOME ☐ A LOT	LAST DATE: ___/___/_____
☐ Cortisone injections: #____________	☐ NONE ☐ SOME ☐ A LOT	LAST DATE: ___/___/_____
☐ Viscosupplementation injections: #________	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED
☐ Positional changes (i.e. lifting arm over head)	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED

Other:____