

New Problem Intake Form



Please complete information below

Today's Date: ____/____/____

Name: _____ DOB _____ Age _____ ☐ Male ☐ Female

Referring Physician _____ FAX _____
Address _____ Phone _____

Primary Care Physician _____ FAX _____
Address _____ Phone _____

Is this a work related problem? Yes ___ No ___ If yes, list your OWCP or L&I # _____
If disabled, when did you last work? _____

Is this a Motor Vehicle Accident related problem? Yes ___ No ___

Do you currently reside in a skilled nursing facility? Yes ___ No ___
If so where? _____
From what dates? _____

Chief Complaint: _____ ☐ Right ☐ Left ☐ Both

When did this problem begin (date of injury): _____ Hand Dominance? Right ☐ Left ☐

How did it happen: _____

Circle the symptoms that best describe your problem: Stiffness Pain Instability Numbness Swelling
Other _____

If you have pain, please circle the description that is most appropriate:
Sharp Throbbing Aching Burning Stabbing Heavy Dull

Circle the number corresponding to the intensity of your pain:
(0 = no pain and 10 = the worst pain imaginable) 0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing?
Better Gradually Better Rapidly Worse Gradually Worse Rapidly Staying the Same

Circle what improves your symptoms? Rest Ice Heat NSAID Splinting Massage
Other _____

Circle what worsens your symptoms? Activity Cold Pressure Other _____

What studies or treatments have you had for this problem? (Circle all that apply)
X-rays CT MRI Nerve study (EMG) Arthrogram Bone Scan Surgery

Please note any information regarding history, medications and allergies that
may have changed since your last visit

Social History

What is your height and weight?
Height in feet and inches _____ Weight in pounds _____

Do you smoke?
Yes___ No___ If yes, how much of a pack per day? _____ How many years have you been smoking? _____

Were you previously a smoker?
Yes___ No___ If yes, when did you quit and how long did you smoke for? _____

Do you have any children?
Yes___ No___ If so how many children? _____

Do you drink alcohol?
Yes___ No___ If yes, how many drinks per week? _____

Do you drink caffeine?
Yes___ No___ If yes, how many drinks per week? _____

Do you following a specific diet?
Yes___ No___ If yes, which diet? _____

Have you ever had a drug or alcohol problem? If yes, please specify
Yes___ No___

Work status?
Employed _____ Unemployed _____ Disability _____ Student _____ Retired _____ Homemaker _____

Occupation _____ Highest level of education _____

Do you exercise?
Yes___ No___ If yes, how many times per week? _____ What type of exercise? _____

Marital Status?
Single _____ Married _____ Divorced _____ Separated _____ Widowed _____ Domestic partner _____

Personal Medical History

Please circle if you have a history of any of the following,

Allergies	Anxiety	Asthma	Bipolar
Bleeding Disorder	Cancer	Chronic Lung Disease	Coronary Artery Disease
Congestive Heart Failure	Depression	Diabetes	DVT/Clotting Disorder
Fibromyalgia	Heart attack	Heartburn/reflux	Hepatitis ___ (specify type)
High Blood Pressure	High cholesterol	Kidney Disorder	Liver Disorder
Neck Fusion	Psoriasis	Rheumatoid Arthritis	Sleep Apnea
Stroke	Thyroid Disorder	Other _____	

Family History

PLEASE SPECIFY WHICH FAMILY MEMBERS (Indicate maternal or paternal when applicable)

Diabetes	High Blood Pressure	Stroke	Heart attack	Cancer
Depression	Kidney/ Liver Disease	Rheumatoid	Gout	Bleeding Disorder
Arthritis	Autoimmune	DVT/Clotting Disorder	Other	

Surgical History _____

Allergies to Medications or Substances (e.g., particularly eggs or chicken products, latex): _____

Current Medications: _____