Date: _____

Room: _____

Temp: _____

Height: _____

Weight: _____

BP: _____/_____

Patient Intake Form

Please answer <u>all</u> questions on both pages - Circle answers where indicated

Name: _____ **Age:** _____ **DOB:** _____

How did you hear about Dr. Dolce?

I'm a previous Dr. Dolce patient / insurance company / family / friend / Social media / Internet search / our website / athletic trainer / therapist / physician referral

If applicable, name of referring physician: _____

Is this injury / problem work related? Yes / No

WHAT problem brings you to the office today / What hurts?

_____

WHEN were you injured / How long have you had this problem?

_____

HOW did the injury / problem occur? (gradual onset, fall, accident, etc.)

_____

DESCRIBE your pain (circle all that apply): Sharp/Stabbing / Dull / Aching / Numb/ Tingling Burning / Pins + Needles / Popping / Locking / Instability / Swelling / Limping / Constant / Intermittent / Other:_____

RATE your usual pain from this problem on a scale of 0 to 10 (10 being the worst): _____

What makes your pain WORSE: Walking / Standing / Sitting / Car rides / Sports / Running / Twisting / Lifting / Bending / Overhead activity / Reaching back / Pivoting / Sleep / Stairs / Getting up out of a chair / Other: _____

What **TREATMENT** have you had for this problem? None / Tylenol / Advil (NSAIDs) / Steroids Ice / Physical Therapy / Injections / Prior Surgery / Chiropractic or Airrosti treatment / Other: _____

Did the treatment help? Yes/No / Stayed the same / Made it worse

Is the pain: getting better / getting worse / staying the same

Have you ever injured this body part in the past? Yes / No

Smoking History: Never smoked / Current daily smoker / Current occasional smoker / Former Smoker

How much do you smoke per day? _____ Age you began smoking: _____ Year stopped: _____

Do you drink alcohol? Yes / No

How often do you consume alcoholic beverages: daily, several days a week, several days per month, occasionally

Are you currently experiencing any of the following? *Please circle all that apply*

Fever	Shortness of breath	Painful urination	Insomnia
Cough	Heartburn	Depression	Asthma
Skin infection	Anxiety	Vision Loss	Irregular heartbeat
Seizures	Hearing Loss	Chest Pain	Dizziness
Night Sweats	Wheezing	Weight Loss	Rash

Please list current and past **medical problems** (Diabetes, High blood pressure, etc.) _____

_____

_____

Family History (Parents and Siblings only) *Please indicate which family member per diagnosis*:

Osteoarthritis (arthritis)	Diabetes	COPD
Rheumatoid arthritis	Renal Disease	Hypertension
Heart Disease	Cancer	Stroke

What **medications** do you take on a regular basis? _____

_____

Allergies to medications, latex, shellfish or Iodine? *Please list*: _____

Pharmacy: _____

Pharmacy Address: _____ Phone#: _____

Patient Signature: _____