Patient Name **Date of Birth**

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Allergies

List all known allergies.

Allergy	Reaction(s)	Date of First Reaction (approx.)
		___ / ___
		___ / ___
		___ / ___
		___ / ___
		___ / ___

Medications

List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.

Medication	Dosage	Frequency

Family History

Check all diseases and conditions that apply.

- ☐ Asthma — Family member(s): _____
- ☐ Bleeding — Family member(s): _____
- ☐ Cancer — Family member(s): _____
- ☐ Diabetes mellitus — Family member(s): _____
- ☐ Stroke — Family member(s): _____
- ☐ Heart disease — Family member(s): _____
- ☐ Hypertensive disorder — Family member(s): _____
- ☐ Malignant hyperthermia — Family member(s): _____
- ☐ Rheumatoid arthritis — Family member(s): _____

Social History

1. Please indicate your current smoking status (Circle one)

Never smoker | Former smoker | Smoker - current status unknown
Current some day smoker | Current every day smoker | Unknown if ever smoked

2. If you smoke, please indicate how much (None is an option) (Circle one)

None 1 PPW 2 PPW
1/4 PPD 1/2 PPD 1 PPD 1 1/2 PPD 2 PPD 3+ PPD

3. Tobacco-years of use (enter 0 if not applicable) _____

4. Please describe your alcohol intake (Circle one)

None Occasional Moderate Heavy

5. Are you currently employed? (Circle one)

Yes No

6. Is this an auto related injury? (Circle one)

Yes No

7. What is your level of education? (Circle one)

Less than 8th 8 9 10 11 12
2 Year College 4 Year College Post Graduate

8. Do you live alone or with others? (Circle one)

alone with others

9. What is your current occupation?

_____

10. Relationship Status (Circle one)

Single Married Separated Divorced Widowed
Unknown Domestic Partner Other

11. Is this a work related injury? (Circle one)

Yes No

12. Are you currently being seen for pain management? (Circle one)

Yes No

13. Are you currently taking prescription pain medications? (Circle one)

Yes No

4. I have received Hospice services this year or am currently receiving Hospice care (Circle one)

Yes No

Surgical History

Check all surgeries that apply.

- Ankle Surgery
- Appendectomy
- Artificial Joint
- Cardiac Surgery/Bypass/OpenHeart
- Cataract Surgery
- Gallbladder Surgery
- Hernia Repair
- Hysterectomy
- Laminectomy
- Mastectomy
- Orthopaedic Surgery
- Prostate Surgery
- Tonsillectomy

Past Medical History

Check all diseases and conditions that apply.

- Alcoholism
- Allergies
- Anemia
- Anxiety/Depression
- Arthritis
- Artificial Joints
- Asthma/ Lung Disease
- Atrial Fibrillation
- Back Pain
- Bleeding Disorder
- Blood Clot/Deep Vein Thrombosis/PE
- Blood Transfusion
- Bowel Disease
- COPD
- Cancer
- Carpal Tunnel
- Cataract
- Chronic Sinus/Rhinitis
- Coronary Artery Disease
- Diabetes
- Dyslipidemia
- Edema
- Emphysema
- Fibromyalgia
- Foot Deformity
- Fractures
- Frost Bite
- GERD/Ulcers
- Gallbladder Disease
- Gout
- HIV or AIDS
- Have you ever had a reaction to ANESTHESIA
- Head Trauma/Injury
- Headaches or Migraines
- Heart Attack (MI)/ Congestive Heart Failure (CHF)
- Hepatitis
- Hernia
- High Cholestrerol
- Hypertension
- Hyperthyroidism
- Hypothyroidism
- Immune Deficiency
- Kidney Disease
- Kidney Stones
- Leukemia
- Liver Disease
- MRSA
- Malignant Hyperthermia
- Muscle, Joint, or Bone Problems
- Neck Injury
- Neurologic Disorder
- Neuropathy
- Obesity
- Organ Transplant
- Osteoporosis
- Other
- Pacemaker
- Parkinson's Disease
- Peripheral Vascular Disease
- Polio
- Rheumatoid Arthritis
- Scoliosis
- Seizures/Epilepsy
- Serious Illness or Injuries
- Sleep Apnea
- Spinal Stenosis
- Stroke
- Substance Abuse
- Thyroid Disease
- Tuberculosis
- Urinary Tract Infection
- Varicose Veins

OAWF Patient Intake Form **Name/DOB**

1	What side of the body part are we seeing you for today?					
	Left	Right	Neither	Notes:		
2	What body part are we seeing you for today?					
	Neck , Arm , Shoulder , Elbow , Wrist , Hand , Finger(s) , Back ,Hip , Leg , Knee , Foot , Ankle , Toe(s)					
3	What is your hand dominance?		LEFT		RIGHT	
4	How long have you had the problem that you are seeing us for today?					
	__weeks	__months	__years	Notes:		
5	How did the problem you are seeing us for occur?					
	Fall	Bending	Lifting	Twisting	Sports injury	Work injury
	Vehicle Accident	Assault	Overuse	Atraumatic	Laceration	Unsure
	Notes:					
6	Are your symptoms	Improving	Worsening	No Change	No Symptoms	
	Notes:					
7	Describe your symptoms:					
	Painless	Sharp	Dull	Stabbing	Tingling	
	Burning	Ache	Pins and Needles	None of the above	No Symptoms	
	Notes:					
8	What makes your symptoms better?					
	Walking	Standing	Sitting	Lying Down		
	Stooping/Bending	Activity in General	Nothing in Particular	No Symptoms		
	Notes:					
9	What makes your symptoms worse?					
	Walking	Standing	Sitting	Lying Down		
	Stooping/Bending	Activity in General	Lifting	Carrying		
	Twisting	Pushing/Pulling	Throwing	Weight-Bearing		
	Exercise	Previous Surgery	Computer Use	Changing Clothes		
	Getting Out of Bed	Going from sit to stand	Upstairs	Downstairs		
	Morning	Daytime	Nighttime	Cold Weather		
	Damp Weather	Nothing in Particular	No Symptoms			
	Notes:					
10	Discomfort level for body part being seen today on a scale of 0-10 (0=none, 10=extreme) is?					
	Discomfort Level __ /10		Worst Discomfort __ /10			

Have you had any recent symptoms below?

Constitutional	weight gain	fever	chills	Notes:
Eyes	loss of vision	Notes:		
Ears	hearing loss	Notes:		
Respiratory	coughing	Notes:		
Cardiovascular	fainting	swelling in lower extremities	Notes:	
Gastrointestinal	nausea	vomiting	heartburn	Notes:
Genitourinary	difficulty with urinating	Notes:		
Musculoskeletal	joint pain	Notes:		
Neurological	memory loss	numbness	loss of strength	Notes:
Psych:	anxiety	depression	Notes:	