

Today's Date: _____

Dr. Danielle DeGiorgio, DO

Confidential Medical History — Initial visit Intake Form

Name: _____ Date of Birth: _____ Date of Injury: _____

Gender: Female Male Dominant Hand: Right Left

Home Phone: _____ Cell Phone: _____

Email Address: _____ Referring Provider: _____

Injured body part _____ Which side is affected? Right Left Both

How did the injury occur or symptoms begin? _____

What is the status of your symptoms, e.g., stable, improving, worsening? _____

When are your symptoms most severe, e.g., morning, evening, at night? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Rate your pain on a scale of 0 (no pain) to 10 (extreme pain): Right now: ___ At best: ___ At worst: ___

What is the quality of your pain, e.g., sharp, dull, burning? _____

Is the pain constant or intermittent? _____

What other symptoms do you have, e.g., stiffness, weakness, popping, swelling, numbness, tingling? _____

Have you seen another physician for your injury/symptoms? Yes No

If yes, who and what was the treatment? _____

Have you experienced anything similar to this in the past? Yes No

If yes, please describe: _____

Have you had any of the following tests or treatments for this problem?

Tests	Date(s) of your tests	Treatments	Describe treatment – did it help?
<input type="checkbox"/> X-ray	_____	<input type="checkbox"/> Medications	_____
<input type="checkbox"/> MRI	_____	<input type="checkbox"/> Injections	_____
<input type="checkbox"/> CT scan	_____	<input type="checkbox"/> Surgery	_____
<input type="checkbox"/> Bone scan	_____	<input type="checkbox"/> Physical therapy	_____
<input type="checkbox"/> Ultrasound	_____	<input type="checkbox"/> Bracing	_____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other	_____

Patient Name: _____ Date of Birth: _____

Medical History

Please list your medical problems, e.g., high blood pressure, diabetes, high cholesterol, depression, and any condition for which you are prescribed a medication, etc.: _____

Females only – Do you think you might be pregnant at this time? Yes No

Surgical History

Have you ever had surgery? Yes No If yes, please describe: _____

Family History

Please list the medical problems of your immediate family, e.g., arthritis, bleeding problems, cancer, diabetes, heart disease, high blood pressure, neurologic problem, osteoporosis, etc.:

Mother: _____

Father: _____

Sibling(s): _____ Not applicable

Social History

Marital status: Single Married Partner Divorced Widowed

Do you have children? Yes No If yes, how many? _____

Are you currently employed? Yes No Retired

If yes, please list your employer and occupation: _____

Do you use tobacco? Yes No If yes, how much and how often? _____

Do you use alcohol? Yes No If yes, how much and how often? _____

Before your current injury/symptoms, please describe your typical physical activity: _____

Are there any upcoming events that may affect your treatment plan, e.g., race, competition, travel? _____

Medications

Please list your current medications, both prescription and over-the-counter: _____

Please list any supplements that you take regularly: _____

Allergies

What medications are you allergic to? _____

Are you allergic to contrast dyes? Yes No Are you allergic or sensitive to latex? Yes No

Patient Name: _____ Date of Birth: _____

Review of Systems

Check any symptom below that you are currently experiencing or have experienced in the past weeks:

- | | | | | | |
|------------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|
| Abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glasses | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headache | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Balance problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood in urine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hot flashes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blurry vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Immune system issue | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bowel incontinence | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insomnia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cellulitis (infection) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Irregular heartbeat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cold intolerance | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint stiffness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Constipation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Muscle aches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Contacts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nose bleeds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Coordination problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pain with urination | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ringing in ears | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seasonal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Double vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Easy bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Easy bruising | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sore throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eating disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Urinary incontinence | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive thirst | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight gain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fatigue | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fever/chills | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wheezing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

What goals do you have for today's visit? _____

Is there anything else that you would like your care team to know about you? _____

Would you like today's note to be sent to another physician? Yes No

If yes, please complete a Medical Release form and provide your doctor's information.
The Medical Release form can be found at the front desk.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____