THE POLYCLINIC

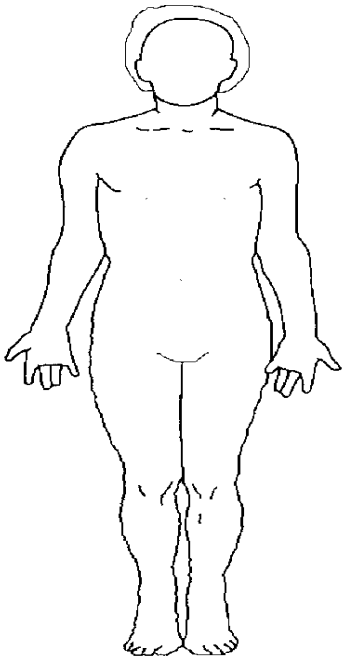
Physical Medicine & Rehabilitation
Intake Form

Name:_____ **Age:**_____ **Date:**_____

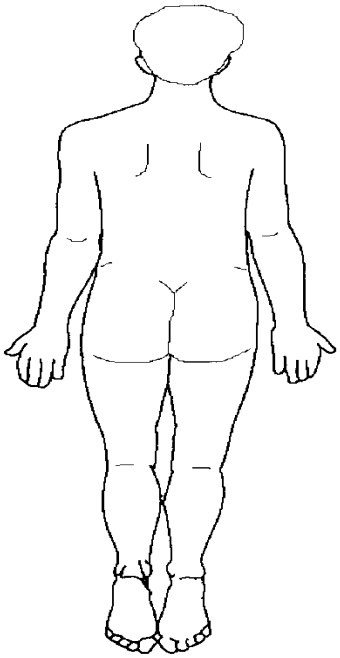
PAIN DIAGRAM. Mark the areas on your body where you now feel your typical pain. Include all areas. Use the following symbols below. (If you have no pain skip to next page.)

Pain XXXXXX Numbness OOOOOO Pins and needles ////////////

Put a large **X** over the spot that you have the most pain



FRONT SIDE



BACK SIDE

PLEASE CIRCLE ALL THAT APPLY:

- **How long have you had your pain?** ____Weeks ____Months ____Years
- **How often do you have your pain?** Constant Comes and goes
- **What caused the onset of pain?** Work Auto accident Lifting Twisting Fall Sports Other Unknown
- **Pain progression?** Better Worse Unchanged
- **Quality of pain?** Stabbing Shooting Aching Burning Cramping Sharp Dull None Other _____

How severe is your pain at worst? **1 2 3 4 5 6 7 8 9 10**
(0=no pain, 10=worst pain imaginable)

How severe is your pain at best? **1 2 3 4 5 6 7 8 9 10**

What makes the pain worse?

What makes the pain better?

Have you had any of the following? MRI CT scan Bone scan X-rays Nerve testing (EMG)
(please circle) None Other_____

Massage PT Chiropractor Acupuncture Injections
Meds None Other_____

Consult with a medical/surgical specialist_____

REVIEW OF SYSTEMS. Mark any of the following symptoms that you have had during the past year.

CONSTITUTIONAL SYMPTOMS
___Recent weight change
___Fever or chills
___Night sweats
___Lack of energy or fatigue
___none of the above

EYES
___Eye pain or redness
___Loss of vision
___Blurred vision or double vision
___none of the above

EARS/NOSE/MOUTH/THROAT
___Hearing loss
___Ringing in ears
___Nose bleeds
___Difficulty swallowing
___Hoarseness
___none of the above

CARDIOVASCULAR
___Chest pain
___Abnormal heartbeat
___Shortness of breath with activity
___Shortness of breath when lying flat
___Swelling of feet or ankles
___none of the above

RESPIRATORY
___Chronic or frequent coughs
___Coughing up blood
___Breathing problems
___none of the above

GENITOURINARY
___Bloody urine
___Urgency of urination
___Frequency of urination
___Painful or difficult urination
___Dribbling or incontinence of urine
___Numbness over groin, genitalia or buttocks
___Sexual difficulties
___none of the above

MUSCULOSKELETAL
___Joint pain, stiffness, or swelling
___Muscle pain or cramps
___Increased pain with laying flat
___none of the above

SKIN/BREAST
___Rash
___Skin sores or ulcers
___Breast pain, lump or discharge
___none of the above

STOMACH AND INTESTINES
___Frequent nausea or vomiting
___Bloody vomiting
___Abdominal pain
___Recurring diarrhea
___Blood in stools
___Frequent or severe constipation
___none of the above

NEUROLOGICAL
___Headaches
___Light headedness or dizziness
___Convulsions or seizures
___Numbness or tingling in arms or legs
___Weakness in arms or legs
___Frequent falls
___none of the above

PSYCHIATRIC
___Difficulty sleeping
___Loss of appetite
___Memory loss or confusion
___Nervousness or anxiety
___Stress
___Depression
___none of the above

ENDOCRINE
___Easy bleeding or bruising
___Swollen glands or lumps in neck, armpits or groin
___none of the above

ALLERGIC/IMMUNOLOGIC
History of allergic reaction to:
___Penicillin or other antibiotics
___Morphine, Demerol, or other narcotics
___Vaccines or anesthetics
___none of the above

OTHER (please list any other symptoms)

_____

_____

_____

PAST MEDICAL HISTORY. **Mark any condition that you have had.**

___High blood pressure
___High cholesterol
___Abnormal heart rhythm
___Heart disease
___Asthma
___Emphysema
___Pneumonia
___Tuberculosis
___Migraine headaches
___Seizures
___Head injury
___Stroke or TIA
___Depression
___Fibromyalgia
___Drug or alcohol addiction
___Diabetes
___Thyroid problems
___Osteoporosis
___Broken bones
___Arthritis or Gout
___Reflux or GERD
___Irritable bowel syndrome
___Stomach/duodenal ulcer
___Gallbladder disease
___Liver disease
___Polio
___Cancer
___Chronic use of Prednisone
___IV drug use
___HIV infection
___None of the above

Please list any other illnesses, hospitalizations, injuries, or operations.

ALLERGIES. **List all allergies to medications.**

MEDICATIONS. **List your current medications with dosages.**

CURRENT MEDICAL ISSUES. **List any other current medical problems.**

FAMILY MEDICAL HISTORY. **List any illnesses that run in the family.**

(Example: diabetes, cancer, stroke, heart problems, muscle problems, nerve problems, depression, alcoholism, etc.)