ADVANCED WELLNESS

Initial Medical Intake PIP

Date: ___________________

Name:___________________________ **DOB:**___________________

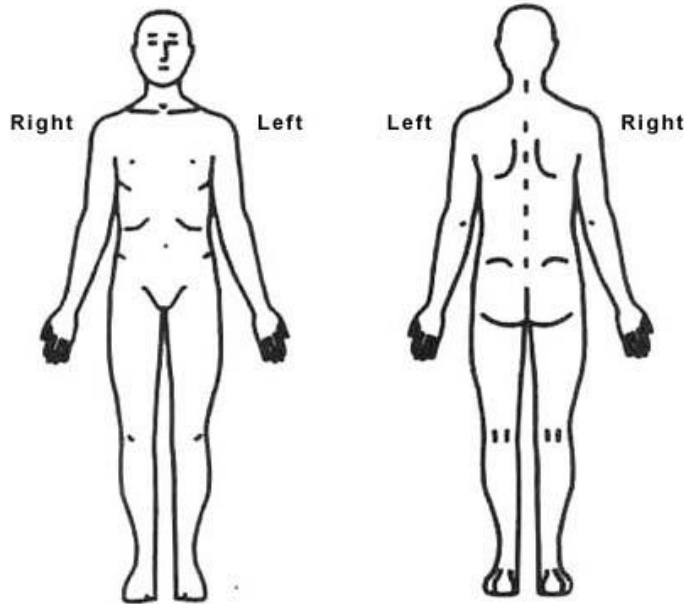
Age: ____________________________ **REFERRING PHYSICIAN:** ________________________

What is the reason for your visit today:____

PAIN DRAWING

/// STABBING **XXX BURNING** ***** TINGLING** **❍❍❍ NUMBNESS** **+++ ACHING**

Where is your pain:



Rate your pain level from 0-10 (0=no pain, 1-3=mild, 4-6=moderate, 7-9=severe, 10=worst pain possible)

Neck Pain:	0	1	2	3	4	5	6	7	8	9	10
Midback Pain:	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain:	0	1	2	3	4	5	6	7	8	9	10
______ Joint Pain:	0	1	2	3	4	5	6	7	8	9	10

When did your pain/symptoms begin:_____________________________

Where you the: Driver____ Passenger_____ Pedestrian_______

Where you wearing your seat belt? Yes No

What type of vehicle were you in: ___________________________________

What type of vehicle was the other vehicle: _______________________________

How did the accident happen: ____
____
____

Where did the accident occur: ____

Did any part of your body hit the interior of the vehicle? ____

Did you lose consciousness? YES NO **For how long?**____

Did the air bags deploy? YES NO

Did you go to the emergency room? YES NO, Where?_____________________________________
Did you go: Right after the accident____________ The next day___________ Other________

How did you go to the ER? By Ambulance Other:______________________________________

Where you discharged home the same day? YES NO

Any motor vehicle accidents in the past? ________ If yes explain:_________________________________

Other symptoms associated with pain: Numbness Tingling Muscle Spasm Weakness
Headache Dizziness Difficulty Walking Clicking/Grinding
Bowel/bladder leakage Decreased Movement Joint Swelling Joint Stiffness

Is the pain: Dull Aching Sharp / Stabbing Throbbing Burning Pins/Needles
Tight / Cramping Soreness Shooting

Does the pain: Radiate down the RIGHT or LEFT arm, down to the SHOULDER / ELBOW / HAND
Radiate down the RIGHT or LEFT leg down to the HIP / THIGH / KNEE / ANKLE / TOES

Is the pain: Constant Intermittent (comes and goes)

Is the pain getting: BETTER WORSE STAYING THE SAME FLUCTUATING

What makes the pain worse: Standing Sitting Walking Movement Lying down
Bending forward Bending Backwards Lifting Bowel Movement
Cough/Sneeze Hot weather Cold weather Other:______________________

What makes the pain better: Standing Sitting Walking Movement Lying down
Rest Massage Elevating area Ice Heat Medications Other:__________

What treatments have you had for the pain: Physical therapy Chiropractic Acupuncture
Massage Trigger Point Injection Epidural Injection Facet Injections Joint Injections

What medications have you taken for the pain: ____

Does the pain affect your quality of life and/or physical functioning? YES NO

How is your sleep: Good Fair Poor

Any other Neck, Back, or Joint injuries in the past? ____

Have you had any tests in past 5 years: MRI CT Xrays Bone Density Bone Scan Other:_________
Where was this done:____

Past Health History/Medical Conditions: ____

____

Past Surgeries / Procedures: ____
____

Drug/Environmental Allergies: ____

Current Medications: ____
____

Family History: ____

Social History: Current Alcohol intake: _________________ Past Alcoholism? _____________

Tobacco Use: ________ How much? _______________ Drug use: _____________________

Any past drug abuse or addiction issues? _____________ Past drug rehab?_______________

Occupation:________________________________; Full-time___ Part-time_______

If unemployed or on leave what was date you last worked: __________________________________

Married____ Single____ Divorced____ Widowed_____; Do you have children?_________

Level of education: High School___ College____ Graduate School____ Other:___________

Do you have any of the following: (circle all that apply)

GENERAL: Changes in appetite or weight, Fatigue, Fever, Chills, Night Sweats, Weakness

MS: Bone Pain, Joint Stiffness, Red/Swollen joints, Deformed joints

Skin: Rashes, Lumps, Acne, Dryness, Discoloration, Changes in hair / nails / moles, Itching, Recurrent skin infections, Skin ulcers, Hypersensitivity

HEENT: Head injury, Visual changes, Double vision, Blurred vision, Earache, Eye pain, Glaucoma, Cataracts, Hearing changes, Runny nose, Toothaches, Hoarseness, Dentures, Ringing in ears, Vertigo, Dizziness, Frequent colds, Nose bleeds

Respiratory: Cough, Coughing up blood, Shortness of breath, Wheezing, Choking or Gasping for air at night, Exposure to Tuberculosis

Cardiovascular: Chest pain, Irregular heartbeat, Palpitations

Gastrointestinal: Abdominal pain, Changes in bowel movements, Constipation, Diarrhea, Heartburn, Blood in stools, Black stools, Nausea, Vomiting, Leakage of stool

Urinary: Pain or burning with urination, Sudden urge to urinate, Trouble starting urination stream, Leaking of urine, Pain in sides, Change in urination

Genital/Reproductive: Sexual difficulties, Painful sexual intercourse

Neurological: Seizures, Tremors, Memory loss

Endocrine: Cold intolerance, Heat intolerance, Excessive sweating, Excessive urination, Excessive thirst

Psychiatric: Anxiety, Sleep disturbance, Irritability, Depression, Mood swings, Suicide thoughts or actions

Height: _____feet, ________inches **Weight:____________________lbs**

I have completed this form & carefully reviewed its contents. I attest to the accuracy & correctness of the information

Patient or Guardian signature:____ Date:__________________

Reviewed by: ___________________________________