NEW PATIENT INTAKE FORM

Completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We depend on its accuracy and completeness to provide you with the best possible care. Please contact our front desk at (941) 375-3006 if you need assistance with any of the sections on this form.

Patient Information

NAME:____________________ REFERRING PHYSICIAN:____________________

DATE OF BIRTH: __/__/____ PRIMARY CARE PHYSICIAN:____________________

AGE:____________________ TODAY'S DATE:____________________

ALLERGIES

Do you have any drug/medication allergies? ☐ YES ☐ NO

If so, please list all medications you are allergic to:

	Medication Name	Allergic Reaction
1)		
2)		
3)		
4)		
5)		

FAMILY HISTORY

Mark all appropriate diagnoses as they pertain to your first-degree relatives:

- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problem
- ☐ Blood Coagulation Disorder
- ☐ Cerebrovascular Accident
- ☐ Chronic Obstructive Lung Disease
- ☐ Coronary Arteriosclerosis
- ☐ Depression
- ☐ Diabetes
- ☐ Disorder of Thyroid Gland
- ☐ Heart Disease
- ☐ Hypercholesterolemia

☐ Other Medical Problems: ______________________________

☐ I have no significant family medical history

PAST SURGICAL HISTORY

Please list any surgical procedures you have had done in the past:

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Caesarean Section
- ☐ Carpal Tunnel Surgery
- ☐ Cholecystectomy
- ☐ General Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Knee Surgery
- ☐ Neck Surgery
- ☐ Orthopaedic Surgery
- ☐ Plastic Surgery
- ☐ Shoulder Surgery
- ☐ Sinus Surgery
- ☐ Tonsillectomy/Adenoids
- ☐ Other:____________________

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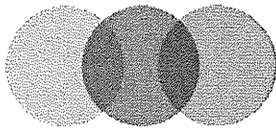

RESTORE
MEDICAL PARTNERS

NEW PATIENT INTAKE FORM
CONTINUED

SOCIAL HISTORY

Tobacco Use

☐ Never Used ☐ Former User ☐ Current Every Day Smoker ☐ Current Some Day Smoker

Packs per day: ________ How many years? _____ Quit Date: _______

Alcohol Use

☐ Social Use ☐ Daily Use ☐ History of alcoholism ☐ None

Caffeine Intake

☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illegal Drug Use

☐ Denies any use ☐ Current user ☐ Former user ☐ Abuse of narcotic or prescription medications?

Occupation: ____________________ When was the last time you worked? ______________

Who is in your current household? ____

Are there any stairs in your current home? ________________ If so how many? ____________

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

PAST MEDICAL HISTORY

Mark the following conditions/diseases that you have been treated for in the past:

	YES	NO		YES	NO		YES	NO
Acid Reflux (GERD)	☐	☐	Headaches	☐	☐	Insomnia	☐	☐
Amenia	☐	☐	Heart Attack	☐	☐	Night Sweats	☐	☐
Anxiety	☐	☐	Heart Value Disorders	☐	☐	Unexplained Weight Gain	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐	Unexplained Weight Loss	☐	☐
Bipolar Disorder	☐	☐	Hyperthyroidism	☐	☐			
Bronchitis/Pneumonia	☐	☐	Hypothyroidism					
Bursitis	☐	☐	Glaucoma	☐	☐			
Cancer	☐	☐	Kidney Stones	☐	☐			
Carpal Tunnel	☐	☐	Low Sex Drive	☐	☐			
Chronic Joint Pains	☐	☐	Migraines	☐	☐			
Chronic Kidney Disease	☐	☐	Multiple Sclerosis	☐	☐			
Constipation	☐	☐	Osteoarthritis	☐	☐			
Coronary Artery Disease	☐	☐	Osteoporosis	☐	☐			
Depression	☐	☐	Peripheral Neuropathy	☐	☐			
Diabetes	☐	☐	Peripheral Vascular Disease	☐	☐			
Dialysis	☐	☐	Rheumatoid Arthritis	☐	☐			
Difficulty Sleeping	☐	☐	Schizophrenia	☐	☐			
Easy Bruising	☐	☐	Seizures	☐	☐			
Emphysema/COPD	☐	☐	Stroke/TIA	☐	☐			
Fatigue	☐	☐	Thyroid Problem	☐	☐			
Fibromyalgia	☐	☐	Urinary Incontinence	☐	☐			
Gastrointestinal Bleeding	☐	☐	Chills	☐	☐			
Head Injury	☐	☐						

Other Diagnosed Conditions

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RESTORE
MEDICAL PARTNERS

NEW PATIENT INTAKE FORM
CONTINUED

DIAGNOSTIC TESTS AND IMAGING

Mark all of the following tests that you have related to your current pain complaints:

☐ MRI of the:____________________

☐ X-Ray of the:____________________

☐ CT Scan of the:____________________

☐ EMG/NCV study of the:____________________

☐ Other Diagnostic Testing:____________________

☐ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist	☐ Neurosurgeon	☐ Psychiatrist/Psychologist
☐ Chiropractor	☐ Orthopedic Surgeon	☐ Rheumatologist
☐ Internist	☐ Physical Therapist	☐ Neurologist

☐ Other____________________

PAIN HISTORY

Chief Complaint (Reason for your visit today)? ____________________

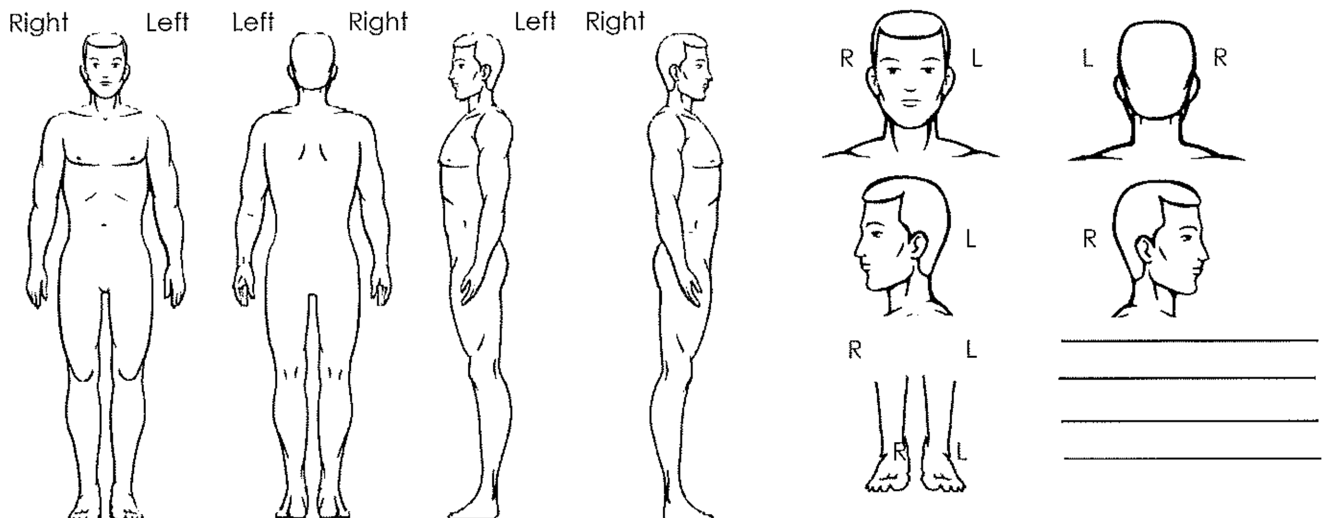
Does this pain radiate? If so, where? ☐ No ☐ Yes

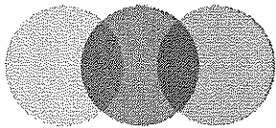
Lower Extremity	☐ Left ☐ Right ☐ Bilateral	Buttock	☐ Left ☐ Right
Groin	☐ Left ☐ Right	Hip	☐ Left ☐ Right

Please list any additional areas of pain:____________________

____

Use this diagram to indicate the area of your pain. Mark the location with an "X"





NEW PATIENT INTAKE FORM
CONTINUED

PAIN DESCRIPTION

Check all of the following that describe your pain:

☐ DULL/ACHING ☐ HOT/BURNING ☐ TIGHTNESS ☐ STABBING/SHARP ☐ CRAMPING
☐ NUMBNESS ☐ THROBBING ☐ TINGLING/PINS & NEEDLES

How often does the pain occur? ☐ CONSTANT ☐ INTERMITTENT (COMES AND GOES) ☐ PAIN @ NIGHT
Severity: ☐ WORSENING ☐ INTERFERES W/ SLEEP ☐ INTERFERES W/ WORK

If "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

RIGHT NOW_______ THE BEST IT GETS:_______ THE WORST IT GETS:_______

ONSET OF PAIN

What Caused your current pain episode? ____

____

When did this pain begin?:____

How did your current pain episode begin? ☐ Sudden ☐ Gradual ☐ Chronic

Intermittent episodes lasting:_________Days _______Months ______Weeks ______Years

Since your pain began how was it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

ALLEVIATING & AGGRAVATING FACTORS

Please circle any and all that apply for pain alleviation and pain aggravation (accordingly)

☐ NOTHING ☐ HEAT ☐ ICE ☐ MEDICATIONS ☐ SITTING
☐ STANDING ☐ STRETCHING ☐ POSITION CHANGE ☐ REST ☐ LYING DOW
☐ EPIDURAL INJECTIONS ☐ PHYSICAL THERAPY ☐ OTHER:____________________

☐ CANNOT IDENTIFY ☐ EXTENSION ☐ FLEXION ☐ CARRYING ☐ TWISTING
☐ LIFTING ☐ GETTING OUT OF BED ☐ TRANSITION FROM SITTING TO STANDING
☐ TRANSITION FROM STANDING TO SITTING ☐ WALKING UP/DOWN STAIRS

INTERVENTIONAL PAIN TREATMENT HISTORY

☐ Epidural Steroid Injection (circle all levels that apply) Cervical / Thoracic / Lumbar
☐ Joint Injection – Joint(s):____
☐ Medial Branch Blocks/Facet Injections (circle levels) Cervical / Thoracic / Lumbar
☐ MILD (Minimally Invasive Lumbar Decompression)
☐ Nerve Blocks – Area/Nerve(s):____
☐ Radiofrequency Nerve Ablation (circle levels) Cervical / Thoracic / Lumbar
☐ Spinal Cord Stimulator – Level:____
☐ Trigger Point Injections - Where?:____
☐ Vertebroplasty/Kyphoplasty - Level(s):____
☐ Pain relief with current medications?:__________%
☐ Other:____
☐ Which of these procedures listed above have helped with your pain? ____________________

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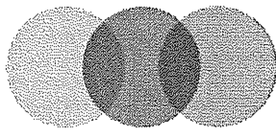

NEW PATIENT INTAKE FORM

CONTINUED

REVIEW OF SYSTEMS

Mark the following you suffer from;

Constitutional:	☐ Chills	☐ Difficulty Sleeping	☐ Easy Bruising	☐ Night Sweats	☐ Fatigue
	☐ Fevers	☐ Insomnia	☐ Tremors	☐ Weakness	
	☐ Unexplained Weight Gain		☐ Unexplained Weight Loss		
Eyes:	☐ Recent Visual Changes		☐ Dry Eyes	☐ Irritation	
Ears:	☐ Difficulty Hearing		☐ Ear Pain	☐ Ear Discharge	
Nose:	☐ Frequent Nose Bleeds		☐ Nose Problems	☐ Sinus Problems	
Mouth/Throat:	☐ Sore Throat		☐ Bleeding Gums	☐ Snoring	
	☐ Dry Mouth		☐ Oral Abnormalities	☐ Mouth Ulcers	
	☐ Teeth Abnormalities		☐ Mouth Breathing		
Cardiovascular:	☐ Chest Pain		☐ Heart Murmur	☐ Blood Clots	
	☐ Arm Pain		☐ Palpitations	☐ Swelling in feet	
	☐ Shortness of Breath While Walking			☐ Shortness of Breath Lying Down	
Respiratory:	☐ Cough		☐ Wheezing	☐ Shortness of Breath	
Gastrointestinal:	☐ Constipation		☐ Acid Reflux/GERD	☐ Abdominal Pain	
	☐ Diarrhea		☐ Nausea/Vomiting	☐ Change in Appetite	
Genitourinary/ Nephrology	☐ Urinary Loss of Control		☐ Difficulty Urinating	☐ Hematuria	
	☐ Pain when Urinating		☐ Vaginal Discharge	☐ Decreased Flow/Frequency	
Musculoskeletal:	☐ Back Pain		☐ Joint Pains	☐ Joint Stiffness	
	☐ Joint Swelling		☐ Muscle Weakness	☐ Neck Pain	
	☐ Limited Motion		☐ Previous Injury	☐ Trauma	
Skin:	☐ Abnormal Mole		☐ Jaundice	☐ Rash	
	☐ Itching		☐ Dry Skin	☐ Skin Lumps	
	☐ Laceration		☐ Growth/Lesions	☐ Redness	
	☐ Bruising		☐ Insect Bites	☐ Flaking	
Neurological:	☐ Dizziness		☐ Headaches	☐ Tremors	
	☐ Numbness/Tingling		☐ Restless Legs	☐ Seizures	
	☐ Loss of Consciousness		☐ Shooting Pain		
Psychiatric:	☐ Depressed Mood		☐ Anxiety	☐ Stress Problems	
	☐ Suicidal Thoughts		☐ Insomnia	☐ Restlessness	
	☐ Hallucinations		☐ Alcohol Abuse		
Endocrine:	☐ Fatigue		☐ Temperature Intolerance		☐ Increased Thirst
Hematologic/ Lymphatic:	☐ Swollen Glands		☐ Easy Bruising		☐ Excessive Bleeding
Allergic/ Immunologic:	☐ Runny Nose		☐ Sinus Pressure	☐ Itching	
	☐ Hives		☐ Frequent Sneezing		
Chest/Breasts:	☐ Lumps		☐ Tenderness	☐ Discharge	

☐ All other review of systems negative ☐ Reviewer:______________________