WILDWOOD FAMILY CLINIC, S.C.
"HEALTHCARE FOR ALL AGES"

Patient Name: _____

DOB: _____

Date: _____

Patient Address: _____

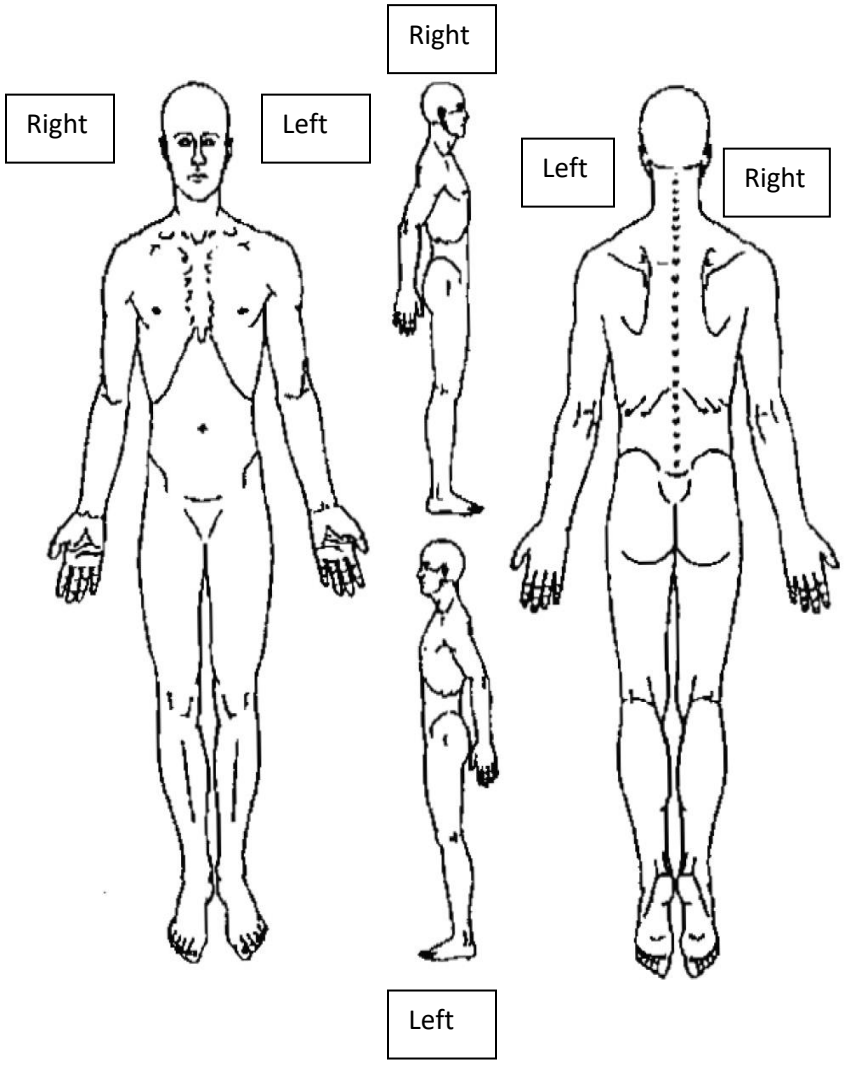
Preferred Phone: _____ Referring Physician: _____

What is the goal of your visit today? _____

Are you currently pregnant? ☐ Yes ☐ No ☐ Not Applicable If YES what is your due date? _____

CHIEF COMPLAINT:

Mark in the areas of your body where you have symptoms. Include all affected areas. Use the appropriate symbols as indicated below



SEVERE PAIN	*******
MODERATE PAIN	00000000
DULL ACHE	∩∩∩∩∩∩
RADIATING PAIN	↑↓↑↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXX

If more than one area which is worse: _____

How long have you had this problem? _____

Did your symptoms follow an injury? □ Yes □ No if yes, describe: _____

Are your symptoms related to an **auto accident** or **work-related injury**? □ Yes □ No If yes, please list the exact date of injury and brief description of how you were injured. _____

_____

How many hours in a 24 hour day do you experience pain: _____

Circle the number that corresponds to your pain levels over the past 2 weeks:

AT BEST: None 0 1 2 3 4 5 6 7 8 9 10 (WORST IMAGINABLE PAIN)

AT WORST: None 0 1 2 3 4 5 6 7 8 9 10 (WORST IMAGINABLE PAIN)

Describe your pain (circle all that apply): constant; intermittent; deep; aching, dull, shooting, sharp, cramping, stiffness, burning, pins and needles, throbbing, stabbing.

During what time of the day are your symptoms at their best: _____

During what time of the day are your symptoms at their worst: _____

Please list activities that increase your pain: _____

Please list activities that decrease your pain: _____

Have you had similar symptoms before? □ Yes □ No

Have you had previous surgery for your symptoms? □ Yes □ No if yes, describe: _____

Have you had x-rays, MRI, EMG (nerve testing) or other studies for your symptoms? □ Yes □ No

PREVIOUS TREATMENT(S) for the issue that brings you here (e.g. Physical Therapy, injections, chiropractic, etc.)

_____

MEDICAL HISTORY: □ Please see electronic chart; my primary provider is at Wildwood Family Clinic

Please list all of your long-term illnesses, even if under control with medication (e.g. asthma, depression, blood clots, anemia, arthritis, high blood pressure, diabetes). Please list the year condition was diagnosed.

_____

_____

PAST SURGICAL HISTORY: □ Please see electronic chart; my primary provider is at Wildwood Family Clinic

Year: Operation: Where was it done?

_____

_____

_____

REVIEW OF SYSTEMS: √ all that apply

Constitutional
Fever _____
Chills _____
Night sweats _____
Weight loss _____
Loss of appetite _____

Allergy/Immune
Drug allergy _____
Seasonal allergy _____
Food Allergy_____
Iodine allergy _____
Transplant _____

Neurological
Paralysis _____
Tremors _____
Spasticity _____
Seizures _____
Muscle atrophy _____
Weakness _____
History of brain or spinal cord injury _____

Musculoskeletal
Joint stiffness/swelling _____
Muscle pain/swelling ____
Fatigue _____
Fractures _____

Hemo-lymphatic
Anemia _____
Excessive bleeding _____
Easy bruising _____
Lymphoma _____
Leukemia _____
Cancer _____
Lymph node swelling _____

CV/Respiratory
Shortness of breath _____
Wheezing _____
Cough _____
Coughing up blood _____
Chest Pains _____
Palpitations _____
Leg swelling _____

Gastrointestinal
Difficulty swallowing _____
Heartburn _____
Nausea/vomiting _____
Constipation _____
Diarrhea _____
Blood in stools _____
Stomach pain _____
Bowel Incontinence _____

Endocrine
Obesity _____
Thyroid Disorder _____
Diabetes _____
Menopause _____
Menstrual irregularities____
Pelvic pain _____
Addison's disease _____

HEENT
Loss of vision _____
Eye Redness _____
Headaches_____
Dizziness _____
Glaucoma _____

Skin/Integumentary
Rash _____
Ulcer _____
Eczema _____
Hives _____

Genitourinary
Pain urinating _____
Incontinence _____
Blood in urine _____
Dribbling _____
Sexual Difficulties _____

Psychiatric
Poor sleep _____
Depression _____
Anxiety _____
Stress at work/home _____
Panic Spells _____

MEDICINES: ☐ Please see electronic chart; my primary care provider is at Wildwood Family Clinic

List all medicines that you have taken recently. Include vitamins, supplements, herbs, and non-prescription medications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

☐ Please check here if you are currently breastfeeding

ALLERGIES:

Name of medicine/substance Type of reaction Date

_____

_____

FAMILY HISTORY: ☐ Please see electronic chart; my primary provider is at Wildwood Clinic

Spinal Problems ☐ Yes ☐ No If yes, describe: _____

Bleeding Disorders ☐ Yes ☐ No If yes, describe: _____

Heart Disease ☐ Yes ☐ No If yes, describe: _____

Cancer ☐ Yes ☐ No If yes, describe: _____

Diabetes ☐ Yes ☐ No If yes, describe: _____

Autoimmune Disease ☐ Yes ☐ No If yes, describe: _____

Inflammatory Arthritis □ Yes □ No If yes, describe: _____

Other □ Yes □ No If yes, describe: _____

SOCIAL HISTORY:

Working status: □ Working □ Not Working □ Student □ Disabled □ Retired

Primary Occupation: _____ Employer: _____

Marital Status: _____ Do you have Children? □ Yes □ No If yes, please list their ages:

_____

Who lives with you at home? _____

Have you ever smoked? □ Yes □ No Type/Amount: _____ Years: _____ If quit, when? _____

Amount of alcohol consumed in a typical week? _____ Cups of caffeinated drinks per day? _____

Have you used: □ Marijuana □ Cocaine □ Heroin □ Other:_____

Do you exercise regularly? Describe type of exercise, frequency/how often, and duration (ex. Walk three times a week for 30 minutes) _____

How many hours of sleep per night do you get on average? _____

How would you describe the quality of your sleep? _____

Thank you for filling this intake form out, please bring it with to your appointment.

Completed By :_____

Date: _____

If not completed by patient, relationship to patient: _____

** If you have a chronic health condition, please consider filling out a personal health inventory form (anyone is welcome to fill this form out).

Appointment Instructions:

- Please arrive 15 minutes early for your evaluation.

Depending on the body area to be examined, please consider dressing in a way that would facilitate proper examination – see suggestions below:

- Knees and Ankles: Please bring a pair of shorts with you to the appointment
- Backs and Hips: Please wear comfortable clothing- elastic waist or drawstring clothing is preferred
- Shoulder and Necks: Ladies may like to bring a tank top or camisole to the appointment
- Elbow and Wrist: Please wear or bring a short sleeve shirt to your appointment, or have sleeves that will roll up.

Office Use Only:

MRN: _____ *Reviewed by:* _____ *Date:* _____