Baylor Scott & White
SPORTS & PHYSICAL MEDICINE CENTER
PARK CITIES
A member of HealthTexas Provider Network

Sports & Physical Medicine Center
9101 North Central Expressway
Suite 450 • Dallas, TX 75231
469-800-7540 main • 469-800-7545 fax

# New Patient History Intake Form

**Patient Name:** _____ Sex: ❑ M ❑ F **DOB**: ___/___/___ **AGE**: _____

What is the reason for your visit? _____

Who referred you to our office? _____ Primary Care Physician: _____

When did this problem begin? _____

Describe your problem? _____
_____

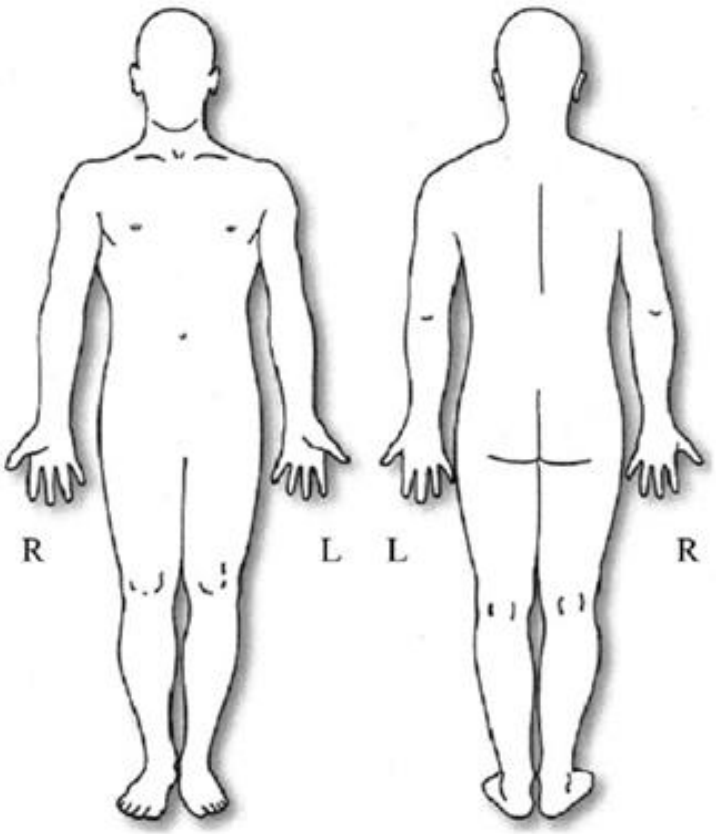
Are you having any pain associated with this problem? ❑ YES ❑ NO

## Rate your PAIN on a scale of 1-10.

*1 being least amount of pain and 10 being the **worst** pain you have ever felt in your life.*

**1 2 3 4 5 6 7 8 9**

**Use VERTICAL lines | | |** to indicate **pain**
**Use HORITZONTAL** lines == to indicate **numbness or tingling**




FRONT BACK

**Check ALL that apply in regards to pain.**

❑ burning ❑ numbness ❑ pins & needles
❑ tingling ❑ dull ❑ sharp
❑ stabbing ❑ throbbing ❑ localized
❑ aching ❑ radiating ❑ shooting
❑ pressure ❑ grinding ❑ constant
❑ intermittent (*every now & then*)

**Is your pain better/worse with the following:**

| Activity | Better? | Worse? |
|---|---|---|
| Sitting | | |
| Standing | | |
| Walking | | |

## Review of Systems

**Check ALL that apply.**

❑ Weight loss/gain ❑ Fever
❑ Night Sweats ❑ _____

❑ Double Vision ❑ Blind Spots

❑ Ringing in Ears ❑ Vertigo/ Dizziness

❑ Shortness of Breath: ❑ At rest ❑ With activity
❑ Chest Pain

❑ Abdominal Pain ❑ Constipation
❑ Incontinence (*Loss of control of Bowel Movements*)
❑ Incontinence (*Loss of control of Urine*)
❑ Sexual Problems

❑ Pressure Sores ❑ Rash

❑ Easy Bruising ❑ Bleeding disorder

❑ Heat / Cold Intolerance ❑ Diabetes

❑ Anxiety/ Depression ❑ Difficulty Sleeping
❑ Falls ❑ _____

❑ Irritability ❑ Lack of concentration
❑ Cognitive Problems ❑ Difficulty Speaking

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❑ Spasm of muscles ❑ Behavioral Problems

❑ Stress in personal life: _____

❑ Any chance that you are pregnant? _____

Describe in detail any checked boxes above:

_____

_____

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**PAST MEDICAL AND SURGICAL HISTORY:** *Please check the boxes of problems you have/ had.*

| | | |
|---|---|---|
| ❑ Heart or blood vessel disease | ❑ Foot or Leg Ulcer | ❑ HIV/AIDS |
| ❑ High/Low Blood Pressure | ❑ Osteoporosis | ❑ Cancer |
| ❑ Lung Disease | ❑ Arthritis | ❑ Bleeding or clotting disorder |
| ❑Liver Disease or Hepatitis | ❑ Spine Surgery | ❑ Depression or mental health |
| ❑ Gastric Ulcers | ❑ Spine and/or Steroid Injections | ❑ Prior EMG/NCS |
| ❑ Kidney Disease | ❑ Seizures | ❑ Prior Therapy |
| ❑ Diabetes | ❑ Stroke | ❑ Surgeries:_____ |

❑ Other:_____

❑ Allergies to Medications:_____

**SOCIAL HISTORY**

❑ Student ❑ Single ❑ Married ❑ Divorced/separated ❑ Widowed Occupation: _____

Use Tobacco products? ❑ Yes Packs/day:_____ Use Alcohol? ❑ Yes ❑ No Year Quit:_____
❑ No ❑ Year Quit:_____ ❑ Socially How Often:_____

Problems with drug or substance use/dependency? ❑ Yes ❑ No ❑ Previously

If yes, please list:_____

Exercise regularly? ❑ Yes ❑ No Type:_____ How Often:_____
Use a cane/walker/wheelchair at home? ❑ Yes ❑ No Need assistance for self care? ❑ Yes ❑ No
Use a cane/walker/wheelchair outside of home? ❑Yes ❑ No
❑ Single Level Home ❑ Multiple Level Home

**FAMILY HISTORY**

❑Cancer ❑Heart Disease ❑Diabetes ❑Arthritis ❑Spine disorders ❑High Blood Pressure ❑Stroke

❑Mental Health Issues ❑Other:_____

**Patient/ Representative:** _____ **Relationship:** _____ **Date:**_____

OFFICE USE ONLY:

**TEMP:** _____ **BP:** ____/___ **HR:** _____ **Respirations** _____ **HT:**_____ **WT:** _____**lbs.**

Appearance: Mood: Orientation:

| | Head/Neck | Spine | L UE | L LE | R UE | R LE |
|---|---|---|---|---|---|---|
| Inspect/palpate | | | | | | |
| ROM, SLR | | | | | | |
| Motor | | | | | | |
| Sensory | | | | | | |

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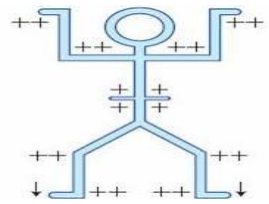

Reflexes Gait Coordination Edema

## Home Medication List

**Date:_____**

**Patient Name:_____ DOB:_____**

**Medication Allergies (Please list.):_____**

**Pharmacy Name:_____ Pharmacy #:_____**

| Name of Medication | Dose (example: mg, g, mcg, puffs, drops) | When do I take this medicine? | | | | | Why do I take it? |
|---|---|---|---|---|---|---|---|
| | | AM | Noon | PM | Bed-time | With Food | |
| | | | | | | | |
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| **Over-the-Counter Medicines (*such as herbals, vitamins, antacids, aspirin*)** | | | | | | | |
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***Note:*** *You will be asked about any new medications upon each office visit by our staff. Medication verification prior to each visit is a National Patient Safety measure which is done in an effort to provide you with the very best care and it ensures that each member of your health care team has a an up-to-date, and accurate medical history.*