SOUTH ORANGE REHABILITATION & WELLNESS

Please complete the following intake paperwork. We rely on its accuracy and completeness to provide you with the best possible care.

Patient Information

Today's date: ______________ Phone#: _______________ Cell#: _________________

Your name: ___________________________ Date of Birth: _______________ Age: _____

Address: ____

Referring Physician: __________________ Primary Care Physician: ____________________

Pain & Symptoms

Reason for your visit today? ____

Approximately when did this pain begin? ____

How did your current pain begin? ☐ Gradually ☐ Suddenly ☐ Other _______________

Pain Description

Check all of the following that describe your pain:

☐ Aching ☐ Burning ☐ Shooting ☐ Stabbing/ Sharp

☐ Numbness ☐ Spasming ☐ Throbbing ☐ Tingling/ Pins and Needles

When is your pain at its worst?

☐ Morning ☐ Daytime ☐ Night time ☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

Associated Symptoms

	No	Yes
Weakness in the arm/leg	☐	☐
Joint Swelling/ Stiffness	☐	☐
Balance Problems	☐	☐
Bladder or bowel changes	☐	☐

Mark the following physicians or specialists you have consulted for your current condition

☐ Chiropractor ☐ Neurosurgeon ☐ Physical Therapist ☐Neurologist ☐ Pain Specialist

☐Orthopedic Physician ☐ Primary Care Physician ☐Other ______________________

Past Medical History

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

General Medical

☐Cancer-Type ____________ ☐Diabetes-Type ___________

Head/Ears/Eyes/Nose/Throat

☐ Headaches ☐ Migraines ☐Head Injury ☐ Hyperthyroidism ☐Hypothyroidism

☐ Glaucoma

Cardiovascular/Hematologic

☐ Pacemaker/Defibrillator ☐ High Blood Pressure ☐ Coronary Artery Disease

☐ Congestive Heart Failure ☐Heart Attack ☐ Stroke/TIA ☐ Irregular Heartbeat

☐ Heart Valve Disorders ☐Peripheral Vascular Disease ☐ Blood clot/Embolism

☐ Infectious Disease (TB, Hepatitis, HIV, etc) ☐ Anemia

Respiratory

☐ Asthma ☐ Bronchitis/Pneumonia ☐ Emphysema/COPD ☐ Sleep Apnea

Gastrointestinal

☐GERD (Acid Reflux) ☐ Gastrointestinal Bleeding ☐ Stomach Ulcers ☐ Constipations

Urological

☐Chronic Kidney Disease ☐Kidney Stones ☐Urinary Incontinence ☐Dialysis

Neuropsychological

☐ Multiple Sclerosis ☐Myasthenic gravis ☐Guillian-Barre ☐ Peripheral Neuropathy

☐Seizures/Epilepsy ☐ Depression/Anxiety ☐Parkinsons

Musculoskeletal

☐Bursitis/Tendonitis ☐Broken bones/ Fractures ☐Weakness in arms/legs ☐Osteoarthritis
☐Osteoporosis ☐Rheumatoid Arthritis ☐Chronic Joint Pains

WOMEN:

☐Pelvic Inflammatory Disease ☐Endometriosis

Are you pregnant or think that you might be pregnant? •YES • NO

Other Diagnosed Conditions:

____

Past Surgical History

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

1) ______________________________ Date? __________
2) ______________________________ Date? __________
3) ______________________________ Date? __________
4) ______________________________ Date? __________

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐YES ☐NO

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other

Please list all the medications you are currently taking, including non-prescription medication:

	Medication Name	Dose (If Known)
1)	______________________	________
2)	______________________	________
3)	______________________	________
4)	______________________	________
5)	______________________	________
6)	______________________	________
7)	______________________	________
8)	______________________	________
9)	______________________	________
10)	______________________	________

Allergies

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

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

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Family History

☐ Cancer ☐ Diabetes

☐ High Blood Pressure ☐ Kidney Problems

☐ Osteoporosis ☐ Rheumatoid arthritis

☐ Stroke ☐ I have no significant family medical history

Social History

Occupation: ____________________________

Employment Status: ☐ Full time ☐ Part-time ☐ Student ☐ Homemaker

☐ 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

Who is in your current household? ____

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

Alcohol Use:

☐ Social Use ☐ History of Alcoholism ☐ Current Alcoholism ☐ Never

☐ Daily use of Alcohol

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used

☐ Packs per day? ______ ☐ How many years? ☐ Quit Date: _______

Do you have a history of chemical dependency? ☐ NO ☐ YES

Patient Signature ______________________________________