

GENERAL INTAKE FORM

First Name _____ Last Name _____ Date ____ / ____ / ____

Male Occupation _____ Email address: _____

Female

May we send you information or follow-up surveys at this email address?

Date of Birth ____ / ____ / ____ Age ____

Yes No

Height ____ft ____in Weight _____ What extremity is bothering you? Knee Elbow
 Shoulder Other: _____

Who referred you to us?

Who is your Internist or Primary Care Physician?

Name _____

Name _____

Address _____

Address _____

Would you like a letter sent to the person who referred you?

Would you like a letter sent to your physician?

Yes No

Yes No

Is a legal case involved with this injury? Yes No

Is this a work related injury? Yes No **(If No, please skip to MEDICAL HISTORY, page 2.)**

Job title _____

How long have you worked for your current employer? _____ years (If less than 1 year _____ months)

Are you:

If you are not working full duty, what date did you last do so? _____ / _____ / _____

When you work, you experience: No limitations

Off Work

Mild limitations

Modified Duty

Moderate limitations

Full Duty

Severe limitations

Not working

Select the best description of any change you have had in work activities since your injury/surgery. Your work activities have:

Not Changed

Decreased

Unable to Work

If yes, check one below:

If yes, check one below:

If yes, check one below:

I have no/slight problems

I now have no/slight problems

I have moderate/significant problems when I work

I have moderate/significant problems

I have moderate/significant problems

For reasons not related to my injury

For reasons not related to my injury

Are you on or planning to apply to any of the following programs?

	<u>Already on it</u>	<u>Applied for it</u>	<u>Planning to apply for it</u>
Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Bach Bush-Joseph Cole Nicholson Romeo

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If your problem is work related, check the response which best describes what you actually do at work **when working full duty**. Check only **one** response in each column.

Sitting	Standing/ Walking	Walking on Uneven Ground	Squatting	Climbing	Lifting/ Carrying	Pounds Carried
<input type="checkbox"/> 0 hr/day	<input type="checkbox"/> 0 hr/day	<input type="checkbox"/> 0 hr/day	<input type="checkbox"/> 0 times/day	<input type="checkbox"/> 0 times/day	<input type="checkbox"/> 0 times/day	<input type="checkbox"/> 0-5 lbs
<input type="checkbox"/> 1 hr/day	<input type="checkbox"/> 1 hr/day	<input type="checkbox"/> 1 hr/day	<input type="checkbox"/> 1-5 times/day	<input type="checkbox"/> 1 flight, 2 times/day	<input type="checkbox"/> 1-5 times/day	<input type="checkbox"/> 6-10 lbs
<input type="checkbox"/> 2-3 hrs/day	<input type="checkbox"/> 2-3 hrs/day	<input type="checkbox"/> 2-3 hrs/day	<input type="checkbox"/> 6-10 times/day	<input type="checkbox"/> 3 flights, 2 times/day	<input type="checkbox"/> 6-10 times/day	<input type="checkbox"/> 11-20 lbs
<input type="checkbox"/> 4-5 hrs/day	<input type="checkbox"/> 4-5 hrs/day	<input type="checkbox"/> 4-5 hrs/day	<input type="checkbox"/> 11-15 times/day	<input type="checkbox"/> 10 flights/ ladders	<input type="checkbox"/> 11-15 times/day	<input type="checkbox"/> 21-25 lbs
<input type="checkbox"/> 6-7 hrs/day	<input type="checkbox"/> 6-7 hrs/day	<input type="checkbox"/> 6-7 hrs/day	<input type="checkbox"/> 16-20 times/day	<input type="checkbox"/> Ladders with weight 2-3 days/week	<input type="checkbox"/> 16-20 times/day	<input type="checkbox"/> 26-30 lbs
<input type="checkbox"/> 8-10 hrs/day	<input type="checkbox"/> 8-10 hrs/day	<input type="checkbox"/> 8-10 hrs/day	<input type="checkbox"/> More than 20 times/day	<input type="checkbox"/> Ladders daily with weight	<input type="checkbox"/> More than 20 times/day	<input type="checkbox"/> More than 30 lbs

MEDICAL HISTORY

Are you currently or have you ever had problems with the following:

	Yes	No	Describe all "YES" responses
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung/Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer or Stomach Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia or other Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other medical condition	<input type="checkbox"/>	<input type="checkbox"/>	_____

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Reviewed by _____ MD Date _____

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Please list all medications you currently use with dosage and frequency (don't forget vitamins, over-the-counter, and herbal medications):

Do you have any medication allergies?

If yes, please list: Yes No

Have you ever had problems with general anesthesia? Yes No

How many surgeries have you had on your affected joint? _____

Please list all past surgeries and hospitalizations:

Surgery/Hospitalization	Date	Physician

FAMILY HISTORY

Does your immediate family (mother, father, sisters or brothers) have a history of any of the following medical conditions?

	Yes	No
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Race:

- White
- Black
- Hispanic
- Asian
- Other

Marital Status:

- Single
- Married
- Divorced/Separated
- Widowed

Do you drink alcohol? Yes No

If yes, how much per week? _____

Do you smoke? Yes No

If yes, how many packs per day? _____

How long have you smoked? _____

Thank you for completing this form!

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Reviewed by _____ MD Date _____

_____|_____|_____|_____|_____|_____|