# New Problem Intake Form

Name _____ Date_____
DOB____/____/____Age____ Sex: ☐M ☐F
Height_____Weight_____ Handedness: ☐ R ☐L
Who referred you here? _____
Who is your PCP? _____

*HISTORY OF CURRENT PROBLEM*
Date your current problem began? _____
Did you ever have this problem before? ☐ Yes ☐ No
If yes, when? _____
Is your problem the result of a (n)...?
☐ Auto Accident ☐ Injury on the job
☐ Recreational Injury ☐ No known cause
☐ Other_____
Describe the original injury if known: _____
_____
Who has treated you for this problem?
Dr. _____ City: _____
Dr. _____ City: _____

TESTS you have had for this problem:
☐ X-Ray ☐ CT scan ☐ MRI ☐ EMG ☐ Other
Date(s) of test(s):_____
Where done: _____

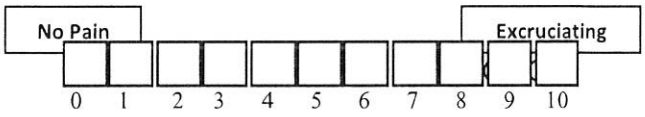
TREATMENTS you have tried for this problem:
☐ Physical Therapy ☐ Acupuncture
☐ Chiropractor ☐ Injections/Nerve blocks
☐ Home exercises ☐ Psychological counseling
☐ TENS Unit ☐ Massage
☐ Braces ☐ Ice/heat
☐ Other_____

Have you had SURGERY for this? ☐ Yes ☐ No
Date and name of surgery: _____
_____

MEDICATION you have tried for this problem:
☐ Aspirin ☐ Ibuprofen (Advil/Motrin) ☐ Naproxen(Aleve)
☐ Tylenol ☐ Celebrex ☐ Diclofenac
☐ Cymbalta ☐ Prozac ☐ Trazodone
☐ Neurontin (Gabapentin) ☐ Nortriptyline (Pamelor) ☐ Amitriptyline (Elavil)
☐ Ultram ☐ Muscle Relaxers (Flexeril/Skelaxin/Soma) ☐ Lyrica
Narcotic Name(s) _____
Other meds tried: _____

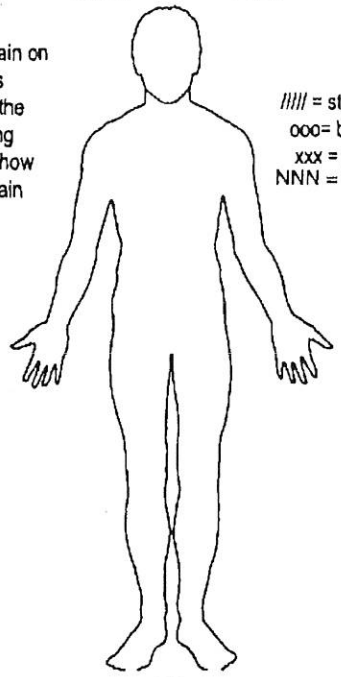
*CURRENT PROBLEM:*
How would you describe you problem?
☐ Constant ☐ Occasional but goes away
☐ Frequent but goes away ☐ Rare
Is your problem worse in the...
☐ Morning ☐ Evening ☐ Nighttime
What makes your problem worse?
☐ sitting ☐ standing ☐ walking
☐ other_____
_____
What makes your problem better?
☐ sitting ☐ standing ☐ walking
☐ other_____

AVERAGE PAIN INTENSITY: Fill in bubble below:



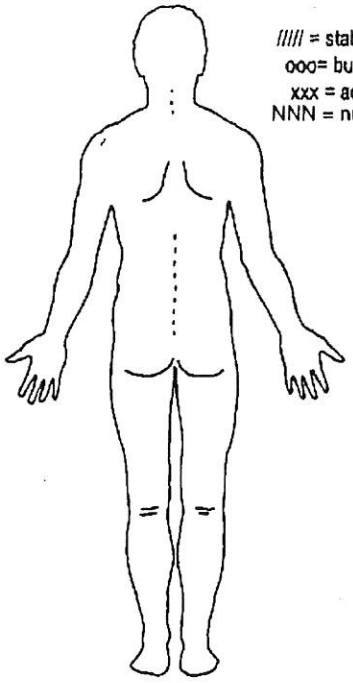

Right Left

**Front**
Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



//// = stabbing pain
ooo= burning pain
xxx = aching pain
NNN = numbness

**Back**



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Left Right

Reviewed by:_____On Date: _____

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*Do you have…*

| | | |
|---|---|---|
| Fevers or chills (unexplained) | ☐ Yes | ☐ No |
| Weight loss (unexplained) | ☐ Yes | ☐ No |
| Incontinence (leak urine or stool) | ☐ Yes | ☐ No |
| Numbness in arms or legs | ☐ Yes | ☐ No |
| Weakness in arms or legs | ☐ Yes | ☐ No |
| Sleep problems | ☐ Yes | ☐ No |
| Do you have an attorney for this issue? | ☐ Yes | ☐ No |

How long can you sit? _____

How long can you stand? _____

How far can you walk? _____

What can you NOT do because of this problem?

_____

Are you currently experiencing any of the following:

- Difficulty swallowing
- Leg swelling
- Cough
- Eye pain
- Chest pain
- Constipation
- Diarrhea
- Easy bruising
- Excessive urination or thirst
- Rash
- Joint swelling
- Immunocompromised
- Balance problems
- Feeling "down

What are your goals for your visit today:

_____

List any other concerns that you have:

_____

I hereby acknowledge that I have had the opportunity to review and/or receive a copy of the HIPPA Notice of Privacy Practices for Michelle Pepper MD PC (available at the front desk).

Patient Signature: _____

Reviewed by: _____ On Date: _____