

New Problem Intake Sheet - BBJP

(Confidential)

Name _____ Referred by: _____

Today's Date _____ Age _____ Birth date _____ Male / Female

Main reason you are being seen today: _____

Date of Onset (approximate) : _____ Which side effected: Right Left Both

Onset: [] Sudden [] Gradual [] AM [] PM [] Intermittent Duration _____

Nature of Pain: [] Sharp [] Burning [] Dull Ache [] Throbbing [] Bruised [] Pins & Needles

Is this related to your job? [] Yes [] No Or a motor vehicle accident? [] Yes [] No

Where did injury occur? _____

Has this ever happened before? [] No [] Yes If yes, when? _____

Have you ever had any prior treatment for this condition and/or injury? [] No [] Yes

If yes, please describe (e.g., surgery, physical therapy, medications, etc.): _____

MEDICATIONS: List medications you are currently taking (include over-the-counter drugs)

ALLERGIES to medications or substances (e.g., particularly eggs or chicken products, latex): _____

Since your last visit have you had any problems with any of the following or told by a physician you have? (please circle any that apply)

AIDS	EPILEPSY	KIDNEY TROUBLE
ANEMIA	GLAUCOMA	STROKE
ARTHRITIS - Osteo / Rheumatoid	GOUT	TUBERCULOSIS
ASTHMA	HEART TROUBLE	ULCER
CANCER (Type _____)	HEPATITIS	VENERAL DISEASE
DIABETES	HIGH BLOOD PRESSURE	VEIN / ARTERY DISEASE

Please list any past surgery and/or hospitalizations you have had: _____

Do you smoke? [] No [] Yes [] Quit if yes, how much per day? _____

Do you drink alcohol? [] No [] Yes if yes, how much per day/week? _____

Have you experienced any recent weight loss? [] No [] Yes recent weight gain? [] No [] Yes

Females only: Are you pregnant? [] Yes [] No [] Maybe

By staff:	Height	Weight	BP	Pulse	Temp
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