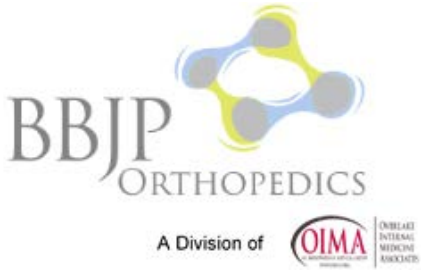
New **Problem** Intake Form



Please complete information below

Today's Date: _____

Name: _____DOB_____Age_____ ☐ Male ☐ Female

Referring Physician_____FAX_____
Address _____ Phone _____

Primary Care Physician_____ FAX _____
Address _____ Phone_____

Is this a work related problem? Yes ◯ No ◯ If yes, list your OWCP or L&I #_____
If disabled, when did you last work? _____

Is this a Motor Vehicle Accident related problem? Yes ◯ No ◯

Do you currently reside in a skilled nursing facility? Yes ◯ No ◯
If so where? _____
From what dates? _____

Chief Complaint: _____ ☐ Right ☐ Left ☐ Both

When did this problem begin (date of injury):_____ Hand Dominance? Right ☐ Left ☐

How did it happen: _____

Select the symptoms that best describe your problem: Stiffness ☐ Pain ☐ Instability ☐ Numbness ☐ Swelling ☐
Other_____

If you have pain, please select the description that is most appropriate:
Sharp ☐ Throbbing ☐ Aching ☐ Burning ☐ Stabbing ☐ Heavy ☐ Dull ☐

Select the number corresponding to the intensity of vour pain:
(0 = no pain and 10 = the worst pain imaginable) 0

How are your symptoms changing?
Better Gradually ☐ Better Rapidly ☐ Worse Gradually ☐ Worse Rapidly ☐ Staying the Same ☐

Select what improves your symptoms? Rest ☐ Ice ☐ Heat ☐ NSAID ☐ Splinting ☐ Massage
Other_____

Select what worsens your symptoms? Activity ☐ Cold ☐ Pressure ☐ Other_____

What studies or treatments have you had for this problem? (Circle all that apply)
X-rays ☐ CT ☐ MRI ☐ Nerve study (EMG) ☐ Arthrogram ☐ Bone Scan ☐ Surgery ☐

Overlake Internal Medicine Associates, P.S.
Patient Profile

REFERRAL INFORMATION

Referred by Physician? ◯ Yes ◯ No

Referring Physician Name: _____

Referred by other (e.g., patient, website, ad) _____

PREFERRED PHARMACY

Pharmacy Name: _____

Location/Neighborhood: _____Phone:_____

By signing below, I hereby authorize Overlake Internal Medicine Associates, P.S. to obtain my Medication History from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

Printed name: _____

Signature: _____ Date: _____

OTHER DEMOGRAPHICS – *(Federal Law Requires That We Ask the Following)*

Preferred Language: ◯ English ◯ Other: _____ ◯ Decline to answer

Race:
- ☐ White
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Decline to Answer

Ethnicity: ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐ **Decline to answer**

EMERGENCY INFORMATION

Person to contact: _____ Phone #: _____

Relationship to patient: _____

May we take your photo to enhance your patient record? ◯ **Yes** ◯ **No**

The information contained in this document is true to the best of my knowledge. I understand that I am responsible for charges associated with medical services and agree to pay all bills from Overlake Internal Medicine Associates within 30 days of receipt of statement, unless other arrangements are made in advance. I authorize the physicians and Overlake Internal Medicine Associates to release any information required to process my insurance claim. I also authorize payment of insurance benefits directly to Overlake Internal Medicine Associates.

Printed name: _____

Signature: _____ Date: _____

For official use only: Patient account number _____