COLUMBIA | REHABILITATION AND REGENERATIVE MEDICINE

New Patient Intake Form

Patient Name: _____ **Today's Date____/____/____**

Date of Birth: ____/____/____ **Primary MD:**

Referred By:

What problem/issue brings you in today?

Is it a pain issue? (Circle one): YES / NO PAIN

(Skip if no pain) Please describe what the pain feels like: Achy, Burning, Cramping, Stabbing, Stiff, Tingling, Numbness, Dull, Tight, Pulling

Please make a *mark on the line* below to indicate the level of discomfort you have today.

No Pain _____ Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

What makes it *worse*? walking sitting standing lying down exercise nothing Other:

What makes it *better*? walking sitting standing lying down exercise nothing Other:

What do you want to accomplish from today's visit? Treatment Options Xrays MRI Medications Injection Diagnosis

What diagnostic tests have you had for this problem? None X-ray MRI CT EMG Other:

What treatments have you had? Meds Physical therapy Chiropractor Psychotherapy Injections Surgery None

Occupational therapy Speech/Language therapy Massage Acupuncture

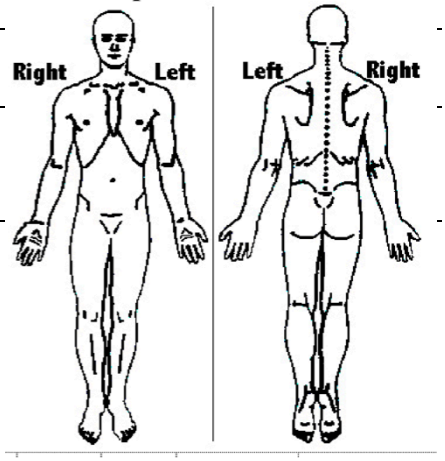
Medical and Surgical History:

Allergies to Medications:

Medications:

Do you take any blood thinning (Anti-coagulant, anti-platelet) medications?

Please shade all locations you have pain or discomfort



Social History

- Exercise:
- Occupation:
- Tobacco Use: (circle one) Current/Quit/Never.
- #Alcoholic Beverages/week _____
- Cannabis/Marijuana use: (circle one) Current/Quit/Never, for medical use: (circle one). Yes/No
- Other recreational/ilicit drug use _____

Review of systems:

- Weakness/numbness Y/N
- Bowel/bladder dysfunction Y/N
- Current musculoskeletal pain Y/N
- Other notable symptoms: _____

Patient's signature: _____. Physicians Initials/Date: _____