**Comprehensive Intake Form - Dr. Shukla**

<u>*Please complete both sides of this form*</u>

***Please bring a list of your current medications (dosages and frequency) with this form***

Name: ______________________ Date of Birth: ____________ Age: ______

Gender: M F Weight: ________ Height: ________ Marital status: S M D W

Home: ____________ Cell: ______________ Work: ______________

Emergency Contact: ______________________________

Relation: ______________________ Tel: ______________

Referring Dr: __________________ Primary Dr: ______________

*Patient Identification*

**Allergies**

| Allergy | Reaction | Allergy | Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Medical History** *(check all that apply)*

Cardiovascular: ☐ High Blood Pressure ☐ Angina/Heart Attack ☐ Cardiac Stent/Bypass ☐ Heart Failure ☐ Irregular Heart Beat ☐ Pacemaker/Defibrillator ☐ Peripheral Vascular Disease

Pulmonary: ☐ Asthma ☐ COPD/Emphysema ☐ Sleep Apnea ☐ Shortness of Breath

Neurological: ☐ Seizures ☐ Stroke ☐ TIA ☐ Multiple Sclerosis ☐ Headache/Migraine

Psychological: ☐ Depression ☐ Anxiety ☐ Panic Disorder ☐ Other __________________

Gastrointestinal: ☐ Ulcer/Heartburn/Reflux ☐ Diverticulitis/Colitis ☐ Hepatitis - Type:_____ ☐ Liver Cirrhosis

Musculoskeletal: ☐ Osteoarthritis/DJD ☐ Rheumatoid Arthritis ☐ Fibromyalgia

Hematological: ☐ Anemia ☐ Low Platelets ☐ Bleeding Disorder ☐ Blood Thinners ☐ Easy Bleeding/Bruising

Renal/Endocrine: ☐ Renal Insufficiency ☐ Dialysis ☐ Diabetes - Insulin Yes / No ☐ Thyroid Disease

Other: ☐ Cancer – Type:__________________ ☐ AIDS/HIV ☐ Other Medical Condition:_____________

**Surgical History**

| Date | Surgery | Date | Surgery |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you had any problems with anesthesia? Yes / No

**Social History**

Tobacco use: ☐ Current ☐ Former ☐ Never Type:____________________ Units/Day:______ Years used:_____

Alcohol use: ☐ Current ☐ Former ☐ Never Drinks/day:______

Recreational Drug use: ☐ Current ☐ Former ☐ Never Type:__________________

Usual Diet: ____________________________________________

Employment: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed Occupation:____________________________

**Family History** *(Check all that apply)*

| Condition | Family Member | Condition | Family Member |
|---|---|---|---|
| ☐ Asthma | | ☐ Diabetes | |
| ☐ Bleeding Disorder | | ☐ Heart Disease / Stroke | |
| ☐ Cancer | | ☐ High Blood Pressure | |
| ☐ Chemical Dependency | | ☐ Other | |

**Review of Systems** *(Check all that apply)*

☐ Chest pain/ palpitations
☐ Shortness of breath
☐ Cough / Wheeze
☐ Weakness / Paralysis of arms/legs
☐ Headaches – frequency:_________
☐ Dizziness / Vision changes
☐ Swelling / Rash
☐ Abdominal pain
☐ Change in bowel habits
☐ Change in bladder habits
☐ Fever / Weight loss / Sweats
☐ Pregnant

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Reviewed by MD_____________________________________________ Date___________

☐ Pneumovax rec'd ☐ Current meds/allergy list, per nursing record, reviewed and found to be accurate. ☐ Tobacco Cessation Counseling

**Comprehensive Intake Form - Dr. Shukla** *Please complete both sides of this form*

Name: ______________________________ Date of Birth: ____________ Age: ________

Patient Identification

**Reason for your visit**: ______________________________

**Pain radiates**: ☐ Yes ☐ No Where? ______________________________

**Date of pain onset**: ________________________

**Pain started:** ☐ Gradually ☐ Suddenly

**Duration:** ☐ Continuous ☐ Intermittent ☐ Changes in severity but always present

**Change over time:** ☐ Improved ☐ Worsened ☐ Stayed the same

**Cause:** ☐ Accident-Date__________ ☐ Work Injury-Date____________ ☐ Surgery____________ ☐Other__________________

**Improves with:** ☐ Sitting ☐ Walking ☐ Standing ☐ Heat ☐ Cold ☐ Exercise ☐ Lying down ☐ Medication______________

**Worsens with:** ☐ Sitting ☐ Walking ☐ Standing ☐ Heat ☐ Cold ☐ Exercise ☐ Lying down ☐ Other___________________

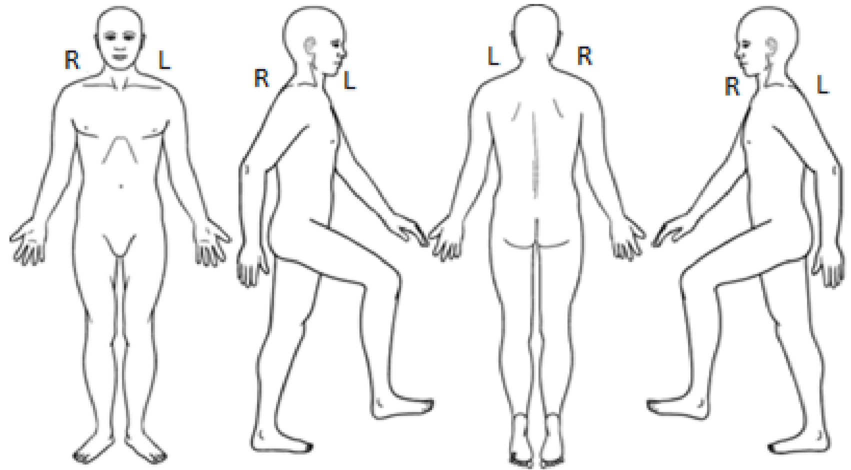
**Affects:** ☐ Concentration ☐ Work ☐ Daily activities ☐ Appetite ☐ Sleep ☐ Recreational Activity ☐ Other:______________

**Describe your pain:**

| | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Throbbing | ☐ | ☐ | ☐ | ☐ |
| Stabbing | ☐ | ☐ | ☐ | ☐ |
| Sharp | ☐ | ☐ | ☐ | ☐ |
| Shooting | ☐ | ☐ | ☐ | ☐ |
| Cramping | ☐ | ☐ | ☐ | ☐ |
| Aching | ☐ | ☐ | ☐ | ☐ |
| Heavy | ☐ | ☐ | ☐ | ☐ |
| Tender | ☐ | ☐ | ☐ | ☐ |
| Splitting | ☐ | ☐ | ☐ | ☐ |

| | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Tingling | ☐ | ☐ | ☐ | ☐ |
| Numbing | ☐ | ☐ | ☐ | ☐ |
| Burning | ☐ | ☐ | ☐ | ☐ |
| Tiring | ☐ | ☐ | ☐ | ☐ |
| Exhausting | ☐ | ☐ | ☐ | ☐ |
| Sickening | ☐ | ☐ | ☐ | ☐ |
| Fearful | ☐ | ☐ | ☐ | ☐ |
| Punishing | ☐ | ☐ | ☐ | ☐ |
| Cruel | ☐ | ☐ | ☐ | ☐ |

On the diagram to the right,
please shade the areas where you have pain.




**Pain Scale** (0 = no pain 10 = unbearable):

At its **best**________

At its **worst**________

At **this moment**________

**Treatments Tried:**

☐ Physical Therapy (when, how long, where) ______________________________

☐ Chiropractor (when, how long, where) ______________________________

☐ Acupuncture (when, how long, where) ______________________________

☐ Injections (when, where) ______________________________

☐ Surgery (when, where) ______________________________

☐ Home Exercise (how long) ______________________________

☐ Other (when, how long, where) ______________________________

**Medications Tried:**

NSAIDS: ☐ Aspirin ☐ Ibuprofen ☐ Advil ☐ Motrin ☐ Naprosyn ☐ Celebrex ☐ Other:__________________

Relaxants: ☐ Flexeril ☐ Valium ☐ Xanax ☐ Ativan ☐ Other:__________________

Antidepressants: ☐ Elavil ☐ Amitryptiline ☐ Prozac ☐ Effexor ☐Zoloft ☐Paxil ☐ Pamelor ☐ Other:_______________

Narcotics: ☐ Vicodin ☐ Norco ☐ Tylenol 3 ☐ Percocet ☐ Ultram ☐ Methodone ☐Other:__________________

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Reviewed by MD______________________________ Date___________