PATIENT INTAKE FORM

DATE: _____

1. PATIENT INFORMATION

Name: First	Last	
DOB:	Date of Injury:	
Address:		
Home Phone:	Cell Phone:	
SSN:	Email:	
Occupation:		
Emergency Contact:	Relation:	Phone:
Insurance Carrier:	Claim Number:	
Case Manager:	Case Manager Phone:	
Adjuster:	Referred By:	

2. PHARMACY INFORMATION

Pharmacy Name:	
Phone Number:	Fax Number (if available):
Address:	

3. ADDITIONAL INFORMATION

Do you live in a house/apartment/townhome?	Are there are stairs?
Who do you live with?	
Other healthcare providers you are seeing (include primary care physician):	

4. MEDICAL HISTORY

a. Are you currently pregnant? ☐Yes ☐ No

b. How would you describe your general state of health? ☐Excellent ☐Good ☐Fair ☐Poor

c. Please indicate any serious conditions, illnesses, injuries, surgeries, or trauma, and any hospitalizations; along with approximate dates:

Injury/Illness/Surgery:	Date:
Injury/Illness/Surgery:	Date:
Injury/Illness/Surgery:	Date:
Injury/Illness/Surgery:	Date:

d. Where is your pain?

_____

e. On a scale of 1-10, with 10 being the highest, how would you rate your pain today?

_____

f. Do you have any allergies (medicines, environmental, food, etc.)?

_____

_____

_____

g. Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.):

_____

_____

_____

For Recovia use only: MED at intake_____

h. Do you use any of the following? (check the box to indicate)
☐Aspirin ☐Laxatives ☐Antacids ☐Diet Pills ☐Birth Control ☐Implants ☐Injections

i. Do you drink alcohol? ☐Yes ☐ No If yes, how frequently? _____

j. Do you use tobacco? ☐Yes ☐ No If yes, how frequently? _____

k. Do you drink caffeinated beverages? ☐Yes ☐ No If yes, how frequently?_____

l. Do you use recreational drugs? ☐Yes ☐ No If yes, what do you use and how often? ____

_____

m. Date of last medical check-up/physical/blood work: _____

n. Have you ever attempted suicide? ☐Yes ☐ No

o. Are you currently having thoughts of suicide? ☐Yes ☐ No

p. Have you ever been given a psychiatric diagnosis? ☐Yes ☐ No
If yes, describe your diagnosis: _____

q. Hobbies:

_____

_____

r. Do you exercise regularly? ☐Yes ☐ No If yes, what do you do for exercise and how often?

_____

_____

5. FAMILY HISTORY

s. Please indicate if a close relative (parent, grandparent, aunt, sibling) has had any of the following: – please write relative(s) next to the item (i.e., “aunt – mother’s side”)

☐ Allergies
☐ Anxiety
☐ Asthma
☐ Attempted Suicide
☐ Alzheimer’s Disease
☐ Cancer
☐ Completed Suicide
☐ Depression
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure

t. How would you describe the emotional climate of your home?

_____

_____

u. How stressful is your work, school, and/or other aspects of your life?

_____

v. How well do you handle these stressors?

_____

w. What are your goals?

_____

_____

x. Is there anything that you feel is important that has not been covered?

_____

_____