OAK BROOK MEDICAL GROUP

Reclaim your life

PATIENT INTAKE FORM

PERSONAL INFORMATION:

First Name:_____Last Name:_____

Date of Birth: _____Age: _____Height: _____Weight:_____

Address_____

City_____State_____Zip_____

Phone_____Email _____

Emergency Contact:_____Relationship to Contact:_____

Emergency Contact Phone Number:_____

Occupation: _____ Employer:_____

How did you hear about us?_____

REASONS FOR TODAY'S VISIT:

What brings you in today? (Primary complaint): _____

When did this start?_____

Was there a specific trauma/injury?_____

What makes the pain worse?_____

What makes the pain better?_____

How would you describe the pain? (circle all that apply):

Achy	*Cramping*	*Stabbing*	*Cold*
Sharp	*Numb*	*Burning*	*Heavy*
Throbbing	*Pins & Needles*	*Swelling*	*Shocks*

How would you rate your pain NOW 0 (no pain) to 10 (worst)?_____

How would you rate your pain when it is at its worst 0 (no pain) to 10 (worst)?_____

What things have you tried to help these problems? (circle all that apply):

Ibuprofen	*Gabapentin*	*Chiropractic*	*Aspirin*
Motrin	*Massage*	*Creams*	*Physical Therapy*
Aleve	*Steroid Injections*	*Pain Medications*	*Acupuncture*

Other:_____

If more than one concern, please list your health problems you would like to be corrected in order of importance:

1. _____
2. _____
3. _____
4. _____

PAST MEDICAL HISTORY:

Have you ever suffered from any of the following, past or present? (circle all that apply)

Back Pain	Bulging Disc	Cancer	Liver Disease
Neck Pain	Spinal Stenosis	Asthma	HIV
Knee Pain	Degenerative Disc	Hypertension	Vertigo
Hip Pain	Plantar Fasciitis	High Cholesterol	Thyroid Disease
Ankle Pain	Osteoarthritis	COPD	Stomach Ulcers
Foot Pain	Rheumatoid Arthritis	Headaches	Fibromyalgia
Hand Pain	Spondylolisthesis	Bleeding disorders	Anxiety
Shoulder Pain	Diabetes	Anemia	Depression
Foot Numbness	Heart Disease	Vascular problems	Other:_____
Hand Numbness	Heart Attack	Pacemaker/Defibrillator	
Herniated Disc	Stroke	Kidney Disease	

PAST SURGICAL HISTORY: Please list any surgeries that you have had.

_____

_____

FAMILY HISTORY: _____

TRAUMAS: Please list any accidents or traumas you have suffered from:_____

_____

ALLERGIES: Please list all allergies/sensitivities to medication, food and other items:

Allergy:	Reaction:
_____	_____
_____	_____
_____	_____

MEDICATIONS:

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all nutritional supplements (vitamins, herbs, homeopathies, et c.) as above:

Name	Dose (mg or IU)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Do you smoke?	Yes	No	If yes, how many cigarettes daily? _____
Do you drink?	Yes	No	If yes, how many drinks daily? _____
Do you exercise	Yes	No	If yes, how much exercise daily? _____

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Acknowledgement of authenticity.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____

Print Name

_____ _____

Signature of Patient, Parent or Guardian Date

Confidentiality.

This is a confidential record of your medical history and pertinent personal information. The medical provider reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

_____ _____

Signature of Patient, Parent or Guardian Date