Alexis Chiang Colvin, MD
Initial Patient Intake Form

Name: _____

Age: _____ **Today's Date**: _____

Marital Status: _____

Occupation/Job: _____

Sports/Hobbies: _____

Recreational/Competitive (circle)

Did another Doctor refer you?
Yes No
If yes, please give name and address:
_____
_____
_____

Where is your problem? (circle)

Shoulder Elbow Hip

Knee Ankle Other

Which side? Right/Left/Both

Dominant arm? Right/Left

Briefly describe your problem:
_____
_____
_____

Work-related injury? Yes/No

Is there a worker's compensation claim? Yes/No

How severe is the pain?
(0=none, 10=severe pain)

At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? Yes/No

Does it waken you from sleep?
Yes/No

Is the pain getting:
Better Worse Same

What makes your problem better?
_____

What makes your problem worse?
_____
_____

Any previous X-rays, MRI, or CT scan?
Y/N Date(s): _____

Any previous treatments?
(medications, physical therapy, injections, bracing, surgery)
_____
_____
_____

Previous surgeries (include dates):
_____
_____
_____

Smoker? Y/N **Amount**: _____

Any medical problems?
_____
_____

Medications (list dose and frequency)
_____
_____
_____

Allergies? _____

Complete back of form also →→→→

Do you have any of the following medical problems? (Please circle)

High blood pressure	Yes / No	Liver problems/hepatitis	Yes / No
Heart problems	Yes / No	Kidney disease	Yes / No
Stroke	Yes / No	Cancer	Yes / No
Ulcers/gastritis	Yes / No	Thyroid disease	Yes / No
Diabetes	Yes / No	HIV or Hepatitis C	Yes / No
Previous blood clot	Yes / No	Asthma	Yes / No

Review of Systems:

1. **General** ☐ None ☐ Recent weight change ☐ Chills ☐ Fever ☐ Weakness/Fatigue
   ☐ Other: _____

2. **Eyes** ☐ None ☐ Vision change ☐ Glasses/contacts ☐ Cataracts ☐ Glaucoma
   ☐ Other: _____

3. **Ear, Nose, Throat** ☐ None ☐ Hearing change ☐ Difficulty swallowing
   ☐ Other: _____

4. **Cardiovascular** ☐ None ☐ Chest pain ☐ Swelling in legs ☐ Irregular heartbeat
   ☐ Other: _____

5. **Respiratory** ☐ None ☐ Shortness of breath ☐ Wheezing/asthma ☐ Frequent cough
   ☐ Other: _____

6. **Gastrointestinal** ☐ None ☐ Acid reflux ☐ Nausea/vomiting ☐ Abdominal pain
   ☐ Other: _____

7. **Musculoskeletal** ☐ None ☐ Muscle aches ☐ Joint Swelling ☐ Joint stiffness
   ☐ Other: _____

8. **Skin** ☐ None ☐ Rash ☐ Ulcers ☐ Abnormal scars
   ☐ Other: _____

9. **Neurological** ☐ None ☐ Headaches ☐ Dizziness ☐ Numbness/tingling
   ☐ Other: _____

10. **Psychiatric** ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood swings
    ☐ Other: _____

11. **Endocrine** ☐ None ☐ Hot/cold intolerance ☐ Excess thirst/hunger
    ☐ Other: _____

12. **Hematologic** ☐ None ☐ Easy bruising ☐ Easy bleeding ☐ Anemia
    ☐ Other: _____