ADVANCED MEDICAL CENTERS

Fibromyalgia New Patient Intake Form

Patient Information

Date: _____ File #: (office use) _____

Name: _____

E-Mail :_____

Phone:_____Cell:_____

Address: _____

_____,_____,_____

City State Zip

Sex: ❑M ❑F Age: _____ DOB:____/_____/_____

❑Single ❑Married ❑Widowed ❑Separated ❑Divorced

SSN:_____

Occupation:_____

Employer:_____

Spouse's Name:_____

Spouse's Employer: _____

Family Physician: _____

Office Use Only: (Circle What Applies)

Patient Records

Pt. brought disc or hard copies:

X-Ray MRI CT Report Other: _____

Need to Request:

X-Ray Images **X-Ray Report**

MRI Images **MRI Report**

CT Images **CT Report**

Date of Records: _____

Location: _____

Physician: _____

Take X-Rays **Staff Initials: _____**

How did you hear about us?

❑Referral from doctor:_____

❑Referral from patient:_____

❑Television channel:_____

❑Internet website:_____

❑Newspaper:_____

❑Other:_____

Chief Complaint (Write Down Your #1 Chief Complaint)

#1 Chief Complaint: _____

Date of Injury/Onset of Pain: _____

Is this condition getting progressively worse? ❑Yes ❑No ❑I Do Not Know

Do your symptoms radiate to:

❑Shoulders ❑Arms ❑Hands ❑Fingers ❑Legs ❑Feet ❑Knees

Type of Symptoms:

❑Sharp ❑Dull ❑Numb ❑Aching ❑Stiff ❑Shooting ❑Throbbing ❑Burning ❑Tingling ❑Cramping ❑Swelling ❑Other_____

How often do you have the symptoms?_____

Is it constant? ❑Y ❑N Comes and goes? ❑Y ❑N

What makes the symptoms worse? _____ Better? _____

Does it interfere with your…? ❑Work ❑Sleep ❑Daily Routine ❑Recreation

Activities/movements that are painful? ❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying down

Please Circle One Number: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain**

Surgical History ❑ I **DO NOT** have a history of any previous surgeries.

Type of Surgery/Year/Surgeon?_____

_____

Treatment History

Past treatments for this condition? ❑Medication ❑Physical Therapy ❑Chiropractic
❑Injections ❑Acupuncture ❑Other _____

Name of doctors who have treated you for your condition?_____

Past Medical History

Alcoholism ☐Y ☐N	Coronary Art Dis ☐Y ☐N	Migraines ☐Y ☐N
Anemia ☐Y ☐N	Depression ☐Y ☐N	Mononucleosis ☐Y ☐N
Anxiety ☐Y ☐N	Diabetes ☐Y ☐N	Multiple Sclerosis ☐Y ☐N
Arthritis ☐Y ☐N	Epilepsy/Seizure ☐Y ☐N	Osteoporosis ☐Y ☐N
Asthma ☐Y ☐N	Gout ☐Y ☐N	Pacemaker ☐Y ☐N
Atrial Fibrillation ☐Y ☐N	Headaches ☐Y ☐N	Parkinson's ☐Y ☐N
Bladder Problems ☐Y ☐N	Heart Disease ☐Y ☐N	Prostate Issues ☐Y ☐N
Blood Clots-legs ☐Y ☐N	Hemophilia ☐Y ☐N	Psychological Dis. ☐Y ☐N
Blood Clots-lungs ☐Y ☐N	Hepatitis A / B / C ☐Y ☐N	Recurrent Infection ☐Y ☐N
Blood Pressure-high ☐Y ☐N	Hernia ☐Y ☐N	STD ☐Y ☐N
Blood Pressure-low ☐Y ☐N	Herpes ☐Y ☐N	Stroke CVA / TIA ☐Y ☐N
Bowel Issues ☐Y ☐N	HIV/AIDS ☐Y ☐N	Thyroid ☐Y ☐N
Cancer _____ ☐Y ☐ N	Kidney/Renal Dis ☐Y ☐N	Ulcer ☐Y ☐N
Cong. Heart Failure ☐Y ☐N	Liver Disease ☐Y ☐N	Other _____
	Lung Problems ☐Y ☐N	_____

Current Medications/Vitamins: ____ See List (I am attaching my medication list)

_____

Social History Exercise? ❑None ❑Moderate ❑Daily Children? ❑Yes ❑No

Habits? Smoking # packs/day_____ Alcohol # drinks/day_____ Coffee/Caffeine # cups/day_____

Current Review of Body Systems (Please check box if **NORMAL**)

Normal	Problem Details	Normal	Problem Details
❑Musculoskeletal	_____	❑Stomach	_____
❑General Health	_____	❑Bladder	_____
❑Eyes	_____	❑Blood	_____
❑Ears/Nose/Throat	_____	❑Neurological	_____
❑Thyroid	_____	❑Psychiatric	_____
❑Breathing	_____	❑Skin	_____
❑Heart	_____	❑Allergic	_____

Are You Pregnant? ❑Y ❑N **Are You Nursing? ❑Y ❑N**

Initial on the Lines Below (You will not be seen by the provider without initialing and signing)

_____ I make my own medical/financial decisions

_____ I do NOT have a Durable Power of Attorney (Person in charge of my **medical** decisions)

_____ I do NOT have a Financial Power of Attorney (Person in charge of my **financial** decisions)

By signing below, I assume full responsibility that all information is accurate, this is my consent for treatment, and I agree to inform this office of any changes in my personal medical status.

Patient Signature: _____ Date: _____

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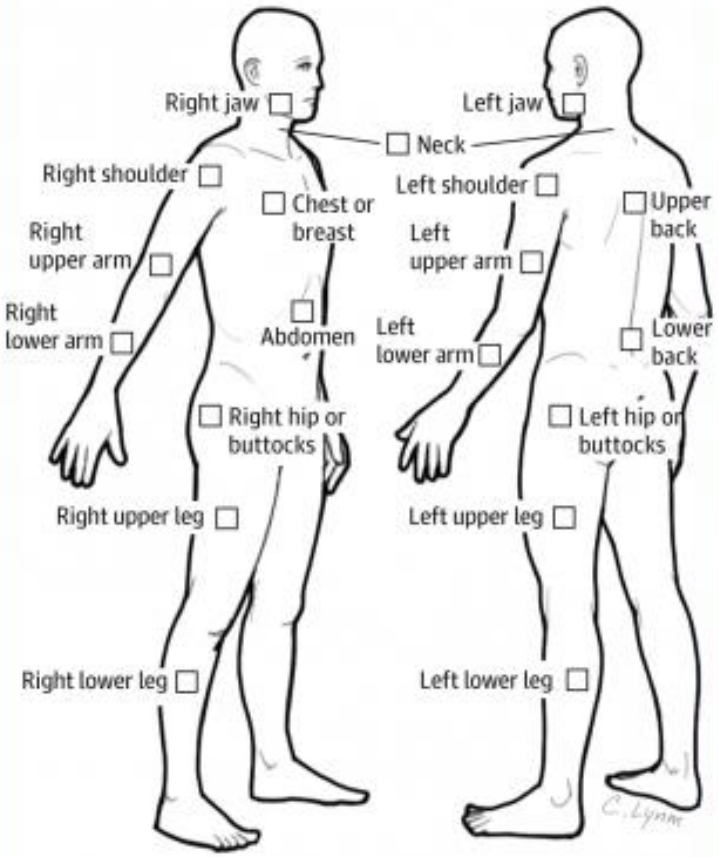
FIBROMYALGIA SCREENING INFORMATION

Widespread Pain Index

1 point per check box. Score range: 0-19 points

(1) Please indicate if you have had pain or tenderness **during the past 7 days** in the areas shown below.

Check the boxes in the diagram for each area in which you have had pain or tenderness.



Symptom Severity Scale

Score Range: 0-12 points

(2) For each symptom listed below, use the following scale to indicate the severity of the symptom **during the past 7 days**.

- **No problem**
- **Slight or mild problem**: generally mild or intermittent
- **Moderate problem**: considerable problems; often present and/or at a moderate level
- **Severe problem**: continuous, life-disturbing problems

	No problem	Slight or mild problem	Moderate problem	Severe problem
Points	**0**	**1**	**2**	**3**
A. Fatigue	☐	☐	☐	☐
B. Trouble thinking or remembering	☐	☐	☐	☐
C. Waking up tired (unrefreshed)	☐	☐	☐	☐

(3) During the **past 6 months** have you had any of the following symptoms?

Points	**0**	**1**
A. Pain or cramps in lower abdomen	☐ No	☐ Yes
B. Depression	☐ No	☐ Yes
C. Headache	☐ No	☐ Yes

Additional Criteria (No Score)

(4) Have the symptoms in questions 2 and 3 and widespread pain been present at a similar level for at **least 3 months**?

☐ No ☐ Yes

(5) Do you have a disorder that would otherwise explain the pain?

☐ No ☐ Yes

Name: _____ **Date:** _____