ADVANCED MEDICAL CENTERS

NEW PATIENT INTAKE FORM - INFLAMMATORY ARTERY & NERVE

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 Cause/Onset of Symptoms: _____

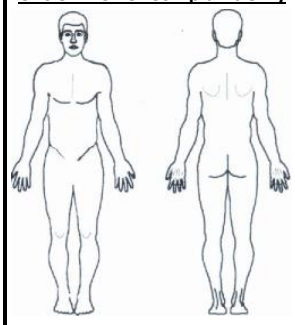
Is this condition getting progressively worse? ❑Yes ❑No ❑I Do Not Know

Circle on the pictures to the right where you have Symptoms:

→→→→ →→→→ →→→→ →→→→ →→→→ →→→→ →→→→ →→→→

Radiates to? ❑Arms ❑Hands ❑Fingers ❑Legs ❑Feet ❑Toes

Circle #1 Chief Complaint Only



Type of Symptoms? ❑Sharp ❑Dull ❑Numb ❑Aching ❑Stiff ❑Shooting ❑Throbbing ❑Burning ❑Tingling ❑Cramping ❑Swelling ❑Decreased Balance

How often, or when 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 ❑Hobbies

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

How Bad Do You Need Help (Circle)? **Not Really-- 0 1 2 3 4 5 6 7 8 9 10 --Urgent!**

Surgical History

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

Type of Surgery/Year/Surgeon?_____

_____

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Treatment History

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

Doctors you've seen for this condition: ❑Family Doctor ❑Cardiologist ❑Endocrinologist ❑Podiatrist ❑Vascular Specialist ❑Rheumatologist ❑Orthopedist ❑Neurologist

Past Medical History

Alcoholism	□Y □N	Coronary Art Dis	□Y □N
Anemia	□Y □N	Stroke CVA / TIA	□Y □N
Arthritis	□Y □N	**Diabetes**	□Y □N
Asthma	□Y □N	Emphysema	□Y □N
Atrial Fibrillation	□Y □N	Epilepsy/Seizure	□Y □N
Birth Defects	□Y □N	Gout	□Y □N
Bladder Problems	□Y □N	**Heart Disease**	□Y □N
Blood Clots-legs	□Y □N	Hemophilia	□Y □N
Blood Clots-lungs	□Y □N	Hepatitis A / B / C	□Y □N
Blood Pressure-high	□Y □N	Hernia	□Y □N
Blood Pressure-low	□Y □N	Herpes	□Y □N
Bowel Issues	□Y □N	HIV/AIDS	□Y □N
Cancer _____	□Y □ N	**Kidney/Renal Dis**	□Y □N
Cong. Heart Failure	□Y □N	Liver Disease	□Y □N
		Lung Problems	□Y □N

Cold Feet	□Y □N
Cold Hands	□Y □N
Leg Pain / Walking	□Y □N
Muscle Weakness	□Y □N
Leg Cramps	□Y □N
Osteoporosis	□Y □N
Pacemaker	□Y □N
Parkinson's	□Y □N
Prostate Issues	□Y □N
Psychological Dis.	□Y □N
Recurrent Infection	□Y □N
Thyroid	□Y □N
Ulcer on Foot/Leg	□Y □N
Other _____	
_____	

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_____

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

1. **Are your feet too sensitive to touch, such as under the bedcovers? □Y □N**
2. **Are your symptoms worse at night, watching TV or during bedtime? □Y □N**
3. **Do your feet/legs hurt when you walk, and feel better when resting? □Y □N**
4. **While in the shower, is it hard to tell hot water from cold water? □Y □N**
5. **Have you ever had an open sore on your foot or leg? □Y □N**
6. **Is the skin on your feet/legs so dry that it flakes or cracks open? □Y □N**
7. **Do you have pain, burning, tingling or numb fingers/hands? □Y □N**
8. **Are you losing grip strength in your hands? □Y □N**
9. **Do you have problems with your balance? □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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