

# Intake form



Main Line HealthCare  
Physician Network

## PATIENT INFORMATION

Name: \_\_\_\_\_

Date of Injury or Onset of Symptoms: \_\_\_\_\_

Date: \_\_\_\_\_

Family Physician, Name/Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

\_\_\_\_\_

Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_

\_\_\_\_\_

Occupation and Employer: \_\_\_\_\_

Physician who sent you here: \_\_\_\_\_

\_\_\_\_\_

Please list all physician specialists that you are currently seeing: \_\_\_\_\_

Are you currently employed: \_\_\_\_\_

\_\_\_\_\_

If not when did you stop? \_\_\_\_\_

\_\_\_\_\_

## REASON FOR VISIT

Please explain **which side**, **how** and **when** things began, describe your symptoms and severity, **what** makes your symptoms better or worse, are things getting any better or worse, any **tests** or **treatment** you may have had for this problem, etc.

Reason for your visit: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CURRENT MEDICATIONS

Please list all medical problems with their corresponding medications (ex. Hypertension, diabetes, etc).

| Medication | Associated Problems |
|------------|---------------------|
| _____      | _____               |
| _____      | _____               |
| _____      | _____               |
| _____      | _____               |
| _____      | _____               |

## DRUG ALLERGIES

Please list allergies to medications: (describe reaction for each): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to take, iodine, or latex?

\_\_\_\_\_

## MAIN LINE HEALTH ORTHOPAEDICS AND SPINE

*Please check or fill in completely.*

**Please list all major surgeries you have had, including dates and side (left or right):**

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**Social history:**

Do you smoke cigarettes? ☐ No ☐ Yes (Number per day)

Have you ever smoked? (how much and for how long) \_\_\_\_\_

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If yes, when did you quit? \_\_\_\_\_

Do you drink? ☐ No ☐ Yes

Have you ever had a drug or alcohol problem? \_\_\_\_\_

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**Please list all major diseases that run in your family:**

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**Review of Systems (please explain all YES answers).**

Have you ever had a problem taking aspirin, Motrin, or other arthritis type medication?

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Have you had a history of recent fevers, sweats, chills, or weight loss?

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Have you had any problems with your heart or blood pressure?

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Have you had any problems breathing or lung problems (ex: asthma, emphysema, cough, etc)?

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Have you had any problems with digestion or bowel problems?

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Have you had any problems with kidney or bladder function (ex: kidney stones, problems with urination)?

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Have you had any problems with other joint or muscles? (arthritis, gout, osteoporosis, etc)?

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Have you had any problems with your skin? (rashes, etc)?

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Have you had any neurological problems (ex: stroke, seizure, dizziness, nerve, or headache)?

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Have you had any endocrine (hormonal) problems such as diabetes (sugar, thyroid, etc)?

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Have you had any problems with anemia, bleeding, or other blood problems?

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Do you have a history of intestinal bleeding?

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Do you have any liver problems (hepatitis, jaundice, etc)?

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Have you had any problems with your eyes, ears, nose, throat, or mouth?

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Please list any other health problems not already mentioned

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Patient signature

Date

Christopher R. Kester, DO

Date