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: ______________________________