  **Medical Intake**

Jack W. Bowling MD Ryan Murphy PA,C James R. Bennett PA,C

**①Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Visit**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Age**:\_\_\_\_\_\_\_\_\_ **Height**:\_\_\_\_\_\_\_\_\_\_\_\_ **Weight**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Onset/Accident/Injury/Surgery**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**② Pain level**: 0 1 2 3 4 5 6 7 8 9 10

 (minimal) (moderate) (maximum)

**Type of Pain**: Constant [ ] Intermittent [ ] Frequent [ ] Occasional [ ] Wakes from sleep [ ]

**Quality of Pain**: Sharp [ ] Dull [ ] Stabbing [ ] Throbbing [ ] Aching [ ] Burning [ ] Shooting [ ] Radiating [ ]

**Pain worsened by**: Sitting [ ] Standing [ ] Walking [ ] Climbing [ ] Kneeling [ ] Bending [ ] Stairs [ ] Weight bearing [ ]

**Other Symptoms**: Swelling [ ] Tingling [ ] Numbness [ ] Weakness [ ] Stiffness [ ] Discoloration [ ]

**Pain relieved by:** Rest [ ] Elevation [ ] Ice [ ] Medication [ ] Other [ ]:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Pain Medications**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rx Refill needed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Physical Therapy/Exercises**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Treatments**: (*please indicate date and type*)

Injection \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brace/other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**③**  **Review of Systems:**  ***please indicate if you are experiencing any of the following***

□ yes □ no Fever/Chills □ yes □ no Blood Transfusion □ yes □ no Anemia

□ yes □ no Mood Changes □ yes □ no Night Sweats □ yes □ no Jaundice

□ yes □ no Headaches □ yes □ no Weight loss/gain □ yes □ no Vision Changes

□ yes □ no Shortness of Breath □ yes □ no Irregular Heart Beat □ yes □ no Chest Pain

□ yes □ no Stomach Ulcers □ yes □ no Limb Swelling □ yes □ no Bleeding Disorder

□ yes □ no Night Pain □ yes □ no Joint Pain

□ yes □ no Frequent/Painful urination



**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Chart**#\_\_\_\_\_\_\_\_\_

**Pharmacy Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold Bowling Orthopaedics responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient/guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_