Baylor Scott & White
PHYSICAL MEDICINE AND REHABILITATION PHYSICIANS
A member of HealthTexas Provider Network

Physical Medicine & Rehabilitation Physicians
Baylor Tom Landry Center • 411 N. Washington Ave
Suite 7300• Dallas, TX 75246
214-820-7140 main • 214-820-7150 fax

New Patient History Intake Form

Patient Name: _____ Sex: M ▫ F **DOB**: ___/___/___ **AGE**: _____

What is the reason for your visit? _____

Who referred you to our office? _____ Primary Care Physician: _____

When did this problem begin? _____

Describe your problem? _____

_____

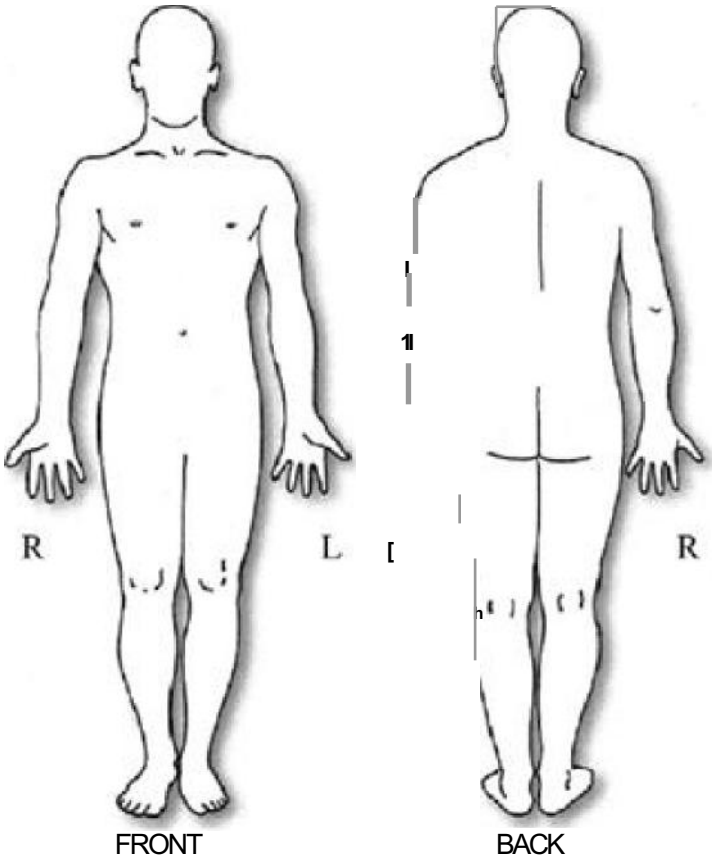
Are you having any pain associated with this problem? ▫ YES ▫ NO

Rate your PAIN on a scale of 1-10.

*1 being least amount of pain and 10 being the **worst** pain you have ever felt in your life.*

1 2 3 4 5 6 7 8 9

Use VERTICAL lines | | | to indicate **pain**
Use HORITZONTAL lines == to indicate **numbness or tingling**



FRONT BACK

Check ALL that apply in regards to pain.

burning ▫ numbness ▫ pins & needles
▫ tingling ▫ dull ▫ sharp
▫ stabbing ▫ throbbing ▫ localized
▫ aching ▫ radiating ▫ shooting
▫ pressure ▫ grinding ▫ constant
▫ intermittent (*every now & then*)

Is your pain better/worse with the following:

Activity	Better?	Worse?
Sitting		
Standing		
Walking		

Review of Systems

Check ALL that apply.

▫ Weight loss/gain ▫ Fever
▫ Night Sweats ▫ _____

Double Vision ▫ Blind Spots
▫ Ringing in Ears ▫ Vertigo/ Dizziness
▫ Shortness of Breath: ▫ At rest ▫ With activity
▫ Chest Pain
▫ Abdominal Pain ▫ Constipation
▫ Incontinence (*Loss of control of Bowel Movements*)
▫ Incontinence (*Loss of control of Urine*)
▫ Sexual Problems
▫ Pressure Sores ▫ Rash
▫ Easy Bruising ▫ Bleeding disorder
▫ Heat / Cold Intolerance ▫ Diabetes
▫ Anxiety/ Depression ▫ Difficulty Sleeping
▫ Falls ▫ _____

Irritability ▫ Lack of concentration
▫ Cognitive Problems ▫ Difficulty Speaking
Spasm of muscles ▫ Behavioral Problems

▫ Stress in personal life: _____

Any chance that you are pregnant? _____

Describe in detail any checked boxes above:

_____

_____

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PAST MEDICAL AND SURGICAL HISTORY: *Please check the boxes of problems you have/ had.*

▫ Heart or blood vessel disease	▫ Foot or Leg Ulcer	▫ HIV/AIDS
▫ High/Low Blood Pressure	▫ Osteoporosis	▫ Cancer
▫ Lung Disease	▫ Arthritis	▫ Bleeding or clotting disorder
▫ Liver Disease or Hepatitis	▫ Spine Surgery	▫ Depression or mental health
▫ Gastric Ulcers	▫ Spine and/or Steroid Injections	▫ Prior EMG/NCS
▫ Kidney Disease	▫ Seizures	▫ Prior Therapy
▫ Diabetes	▫ Stroke	▫ Surgeries: _____

Other: _____

Allergies to Medications: _____

SOCIAL HISTORY

▫ Student ▫ Single ▫ Married ▫ Divorced/separated ▫ Widowed Occupation: _____

Use Tobacco products? Yes Packs/day: _____ Use Alcohol? ▫ Yes ▫ No Year Quit: _____

▫ No ▫ Year Quit: _____ Socially How Often: _____

Problems with drug or substance use/dependency? Yes ▫ No ▫ Previously ▫

If yes, please list: _____

Exercise regularly? Yes ▫ No Type: _____ How Often: _____

Use a cane/walker/wheelchair at home? ▫ Yes ▫ No Need assistance for self care? ▫ Yes ▫ No

Use a cane/walker/wheelchair outside of home? ▫ Yes ▫ No

▫ Single Level Home ▫ Multiple Level Home

FAMILY HISTORY

▫ Cancer ▫ Heart Disease ▫ Diabetes ▫ Arthritis ▫ Spine disorders ▫ High Blood Pressure ▫ Stroke

▫ Mental Health Issues ▫ Other: _____

Patient/ Representative: _____ **Relationship:** _____ **Date:** _____

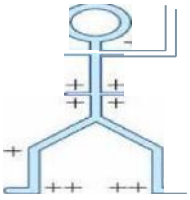
ICE USE ONLY:

TEMP: _____ **BP:** ____/___ **HR:** _____ **Respirations** _____ **HT:** _____ **WT:** _____**lbs.**

Appearance: Mood: Orientation:

	Head/Neck	Spine	L UE	L LE	R UE	R LE
Inspect/palpate						
ROM, SLR						
Motor						
Sensory						

Reflexes Gait Coordination Edema



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Home Medication List

Date: _____

Patient Name: _____ **DOB:** _____

Medication Allergies (Please list.): _____

Pharmacy Name: _____ **Pharmacy #:** _____

Name of Medication	Dose (example: mg, g, mcg, puffs, drops)	When do I take this medicine?					Why do I take it?
		AM	Noon	PM	Bed-time	With Food	

Note: *You will be asked about any new medications upon each office visit by our staff. Medication verification prior to each visit is a National Patient Safety measure which is done in an effort to provide you with the very best care and it ensures that each member of your health care team has a an up-to-date, and accurate medical history.*