

# Siker Medical Intervention Intake Form

Name:	DOB:	Age:	Today's Date:
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PRIMARY CARE PHYSICIAN:			
REFERRING PHYSICIAN:			
Current Medications & Supplements:		ALLERGIES:	
CHIEF COMPLAINT/Reason you are being seen today:			
MEDICAL HISTORY: Current Medical problems/conditions:			
Other conditions/problems your doctor should know about:			
SURGICAL HISTORY			
Date:		Reason:	
Date:		Reason:	
Have you or anyone in your family ever had a complication from surgery?			
FAMILY HISTORY			
Father Diseases:		If deceased what age?	
Mother Diseases:		If deceased what age?	
Siblings Diseases:		If deceased what age?	
Sports/activities you participate in regularly/weekly:			
Tobacco		Chewing: Dips/day:	How many years? Quit how long ago?
Alcohol		# Drinks/day:	#Drinks/month:
Have you used or currently using recreational drugs?			

REVIEW OF SYSTEMS		
General	Recent changes in: <input type="checkbox"/> weight <input type="checkbox"/> appetite <input type="checkbox"/> fever <input type="checkbox"/> energy level	
ORTHO	Any broken bones in the past?	Which bones and when:
	Any joint, pain, swelling, or deformities?	Which joints?
	Any history of arthritis?	
HEENT	Changes in vision or hearing?	
	Difficulty swallowing or persistent hoarseness?	
	Migraine headaches?	
NECK	Swollen glands or masses?	
	Pain or stiffness?	
HEART & LUNGS	Have you ever had a heart attack?	
	Do you or have you experienced: <input type="checkbox"/> Chest pain/angina <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Racing heart/palpitations <input type="checkbox"/> Leg/feet swelling <input type="checkbox"/> Blood clots- DVT-PE	<input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma- Exercise induced asthma <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Coughing
GI/GU	Have you ever experienced: <input type="checkbox"/> Reflux- GERD  <input type="checkbox"/> Bleeding ulcers-H.pylori	<input type="checkbox"/> Difficulty with urine flow  <input type="checkbox"/> Hepatitis A B C other (Circle all that apply)
	Have you or are you receiving treatment for or seen mental healthcare professional for:	
MOOD	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Chronic pain problems <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Seasonal Affective Disorder
	Have you or do you experience:	
NEURO	<input type="checkbox"/> Seizures <input type="checkbox"/> Memory loss <input type="checkbox"/> Unexplained weakness	<input type="checkbox"/> Tremors <input type="checkbox"/> Dizziness <input type="checkbox"/> Stroke/TIA

What is your current pain level on a scale of 0 to 10 scale (10 being the worst)?\_\_\_\_\_

Please list your area(s) of concern. If more than 1, please list in order of importance/concern.

- 1.
- 2.
- 3.

**Please shade the figure to the right identifying area of pain.**

**Please circle all of the following that apply:**

Constant pain

Intermittent pain

Sharp/stabbing pain

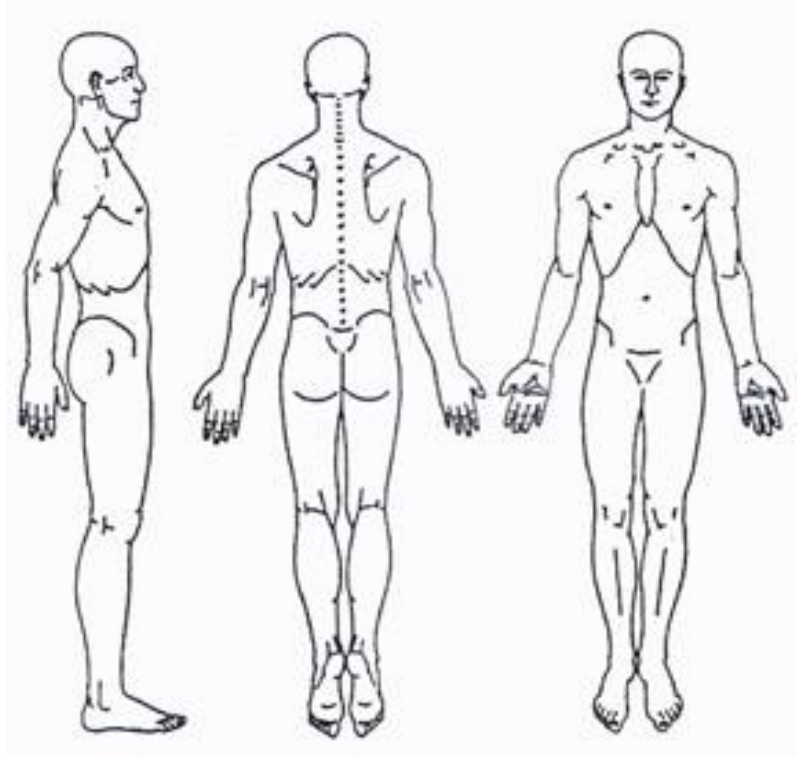
Numbness

Weakness

Burning

Shooting/radiating pain

If other, please explain:



Have you had any of the following? If so, date/location:

MRI:

CT:

X-Rays: