Patient Intake Form

Donald Dolce, MD **Fort Worth Orthopedics**

Please answer all questions – Circle answers where indicated

Date: _____

Room: _____

Temp: _____

Height: _____

Weight: _____

BP: _____/_____

Name: _____ **Age:** _____ **DOB:** _____

Name of primary care physician (PCP): _____

Pharmacy: _____ **Pharmacy Phone#:** _____

Pharmacy Address: _____

How did you hear about Dr. Dolce?

I'm a previous Dr. Dolce patient / insurance company / family / friend / social media / Internet search / our website / athletic trainer / therapist / physician referral: _____

WHAT problem brings you to the office today / What hurts?

_____

WHEN did your symptoms begin / How long have you had this problem?

_____

HOW did the injury / problem occur? (gradual onset, fall, accident, etc.)

_____

DESCRIBE your pain/symptoms (circle all that apply): Sharp/ Stabbing / Dull / Aching / Numb / Tingling / Burning / Pins + Needles / Popping / Locking / Instability / Swelling / Limping / Constant / Intermittent / Other: _____

RATE your usual pain on a scale of 0 to 10 (10 being the worst): _____

Is the pain: improving / worsening / staying the same

What makes your pain WORSE (circle all that apply): Walking / Standing / Sitting / Car rides / Sports / Running / Twisting / Lifting / Bending / Overhead activity / Reaching back / Pivoting / Sleep / Stairs / Getting up out of a chair / Other: _____

What TREATMENT have you had for this problem? None / Tylenol / Advil (NSAIDs) / Steroids Ice / Heat / PT / Injections / Surgery / Chiropractic / Airrosti / Other: _____

Did the treatment help? Yes / No / Made it worse

Have you ever injured this body part in the past? Yes / No

Did this injury occur at work? Yes / No **Do you have a pain management doctor:** Yes / No