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New Patient Medical History & Intake

Please complete this form and bring it to your first appointment. If a question does not apply to you, write "none" rather than leaving it blank.

Patient name _____

Date of birth _____ **Phone** _____

Email _____

Referred by, or how did you find us? _____

Why are you here

What are you hoping Dr. McDonald can help you with?

Your pain, if that is why you are here

Where is your pain? _____

How long have you had it? _____

Right now, rate your pain from 0 (none) to 10 (worst possible) _____

At its worst, rate your pain from 0 to 10 _____

What makes it better? _____

What makes it worse? _____

Did this start with a specific injury or event, or come on gradually?

Medical history

What medical conditions, procedures, and surgeries have you had?

Medications

What medications do you currently take? (You can bring a medication list instead.)

Allergies

What allergies do you have? _____

Current symptoms

Please circle any of the following you are having or have had recently.

fatigue | light sensitivity | sound sensitivity | heart issues | trouble breathing | painful breathing constipation | diarrhea | pelvic pain | muscle cramps | rash | numbness | weakness | tingling | anxiety depression | thyroid problems | weight gain | weight loss | clotting or bleeding problems | food allergies

Family and background

What medical problems are common in your family? You may write "none" or "unknown."

What is your occupation? Please include retirement or disability, if it applies.

Patient signature _____ **Date** _____