Marin Spine & Sports
Marin's Premier Sports Injury Center

New Patient Intake Form

Personal Information

Patient Name: _____ DOB: ____/_____/_____ Sex: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone#: (_____)_____ Email: _____

Who referred you to our clinic? _____

Primary Care Physician: _____

Have you seen a physician, surgeon, or physical therapist for your injury? **Yes** **No**

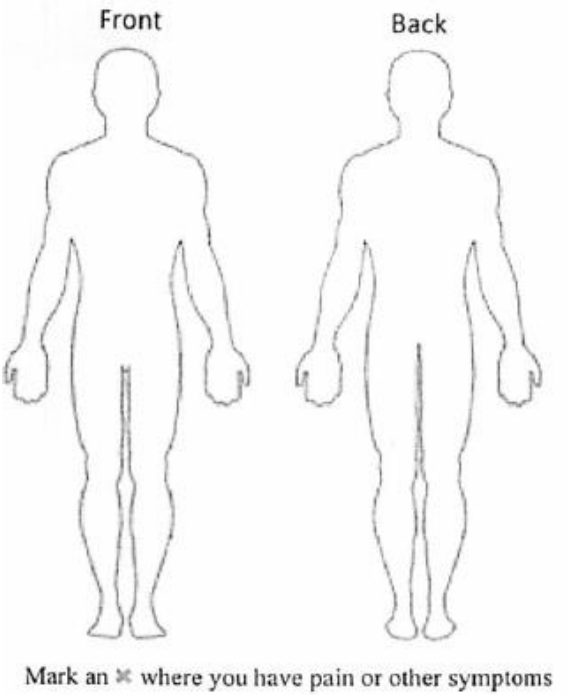
If yes, please explain: _____

Injury Information

Chief Complaint: _____

_____

Date your problem began: ____/_____/_____



Mark an ✖ where you have pain or other symptoms

Nature of your symptoms – check all that apply:

- □ Aching
- □ Burning
- □ Cramping
- □ Deep
- □ Disabling
- □ Dull
- □ Itching
- □ Pressure-like
- □ Sharp
- □ Shooting
- □ Stabbing
- □ Stiffness
- □ Superficial
- □ Tender
- □ Other: _____ _____

Severity: ___/10

My pain is : □ getting better □ worsening □ unchanged

My symptoms are: □ constant □ intermittent

My symptoms are worse: □ In the morning □ afternoon □ evening □ overnight □ during activity □ after activity □ after I'm inactive

Associate Symptoms:

- □ Numbness
- □ Tingling
- □ Weakness
- □ Sensitive to light touch
- □ Locking
- □ Catching
- □ Give way/instability
- □ Swelling
- □ Popping/Cracking
- □ Other: _____
- □ Other: _____
- □ Other: _____

Aggravating Factors:

□ Activity
□ Climbing (stairs)
□ Descending (Stairs)
□ Changing positions
□ kneeling
□ Lifting
□ Lying down
□ Running
□ Sitting (Prolonged)
□ Standing (Prolonged)
□ Squatting
□ Surgery (made it worse)
□ Warm shower
□ Walking
□ Other: _____
_____

Alleviating Factors:

□ Acupuncture
□ Activity
□ Changing positions
□ Chiropractor
□ Cold ice pack
□ Hot packs
□ Injections
□ Lying down
□ Medications (list):
_____
□ Nerve Blocks
□ Physical Therapy
□ Rest
□ Sitting
□ Sleeping
□ Standing
□ Stretching
□ TENS unit
□ Using a brace
□ Warm shower
□ Walking
□ Other: _____
_____

Medical History- Please list any conditions for which you are followed by a physician:

_____

_____

Have you had any imaging studies done? **Yes** **No**

Results:_____

Medications - Prescription and over the counter :

_____

_____

Surgical History - Please include procedure & date:

_____

_____

Family History -Do you have any relatives with conditions relevant to your current symptoms?

_____

_____

Sports/Athletic Activities:

_____

_____

Patient Signature:_____ Date:_____