PALOMAR HEALTH
Corporate Health Services

Established Patient Intake Questionnaire

Patient Identifying Information

Name (Last, First, Middle)	**Sex** ☐ Male ☐ Female	
Birthdate (Month / Day / Year)	**Age**	**Visit Date:**

General Information

Has your Address/ Phone # changed since the last visit? ☐ Yes ☐ No
If Yes, please update the information:

Work Information

Current Work Status (Please check all that apply)

☐ **Working:**	☐ Full-time	☐ Part-time	☐ Modified Work	☐ **Student**	☐ Full-time	☐ Part-time
☐ **Not Working:**	☐ Temporarily Totally Disabled			☐ Temporarily Partially Disabled		
	☐ Permanently disabled			☐ Retired		
	☐ Actively seeking employment			☐ Not Actively seeking employment		

If you are not working, when was your last day of work? Month: ___ Day: ____ Year: ____

Financial Information

Type of Benefit	Benefits Active?
Work Comp Payments	☐ Yes ☐ No

Other family source of income: ☐ Yes ☐ No (if yes, please list):

Are you currently applying for any benefits? ☐ Yes ☐ No
If yes (select all that apply): ☐ State Disability Insurance ☐ Social Security Disability ☐ Other:

Active Financial Stressors: ☐ Yes ☐ No (if yes, please list):

Since last visit to this office

1. Have you seen any other physicians related to this injury? ☐ No ☐ Yes (if yes, whom and why?):
2. Have you had any NEW TESTING performed? (MRI, CT scan, etc.)? ☐ No ☐ Yes (if yes, describe):
3. Have you had any NEW INJURIES or RE-INJURIES? ☐ No ☐ Yes (if yes, describe):

Patient Initials: _____ Reviewed and discussed: Clinician initials: _____ Title: ☐ MD ☐ NP

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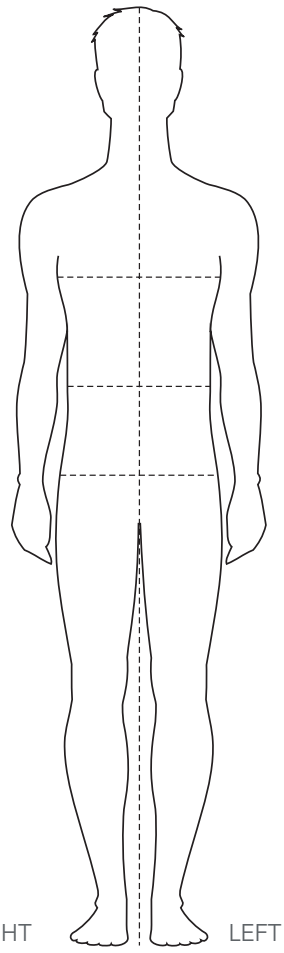
SYMPTOMS

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now, using the following symbols:

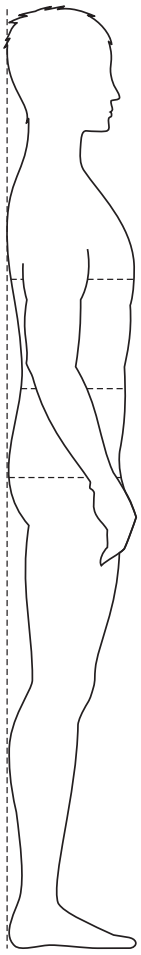
Quality					**Severity**	**Duration**
Numbness – – – – –	Pins & Needles ○○○○○	Burning ^^^^^	Aching ×××××	Throbbing ⊗⊗⊗⊗⊗	1: minimal 10: severe	hours/day
					1–10	**1–24 hrs**

FRONT

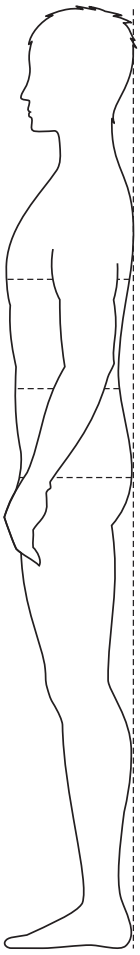


RIGHT LEFT

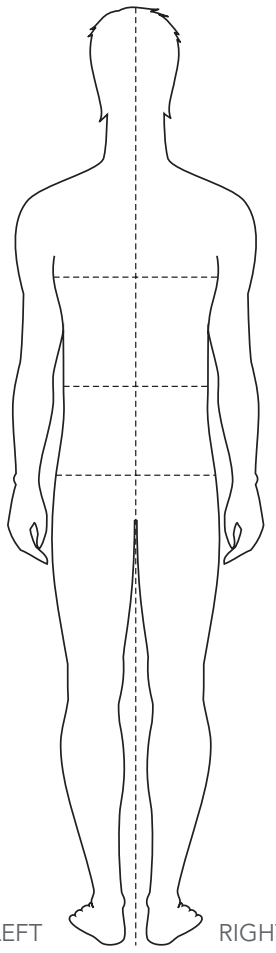
RIGHT SIDE



LEFT SIDE



BACK



LEFT RIGHT

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SYMPTOM QUALITIES

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

Please circle or check the appropriate responses for each item for **each body part** affected

Body Part:						
Pain Quality:	☐ burning	☐ shooting	☐ tingling	☐ radiating	☐ numbing	☐ cramping
	☐ achy	☐ throbbing	☐ pressure	☐ squeezing	☐ dull	☐ deep

Pain Severity: **Minimal** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Severe**

Pain Timing: My pain is: ☐ always there ☐ comes and goes

Pain Duration: As a result of my injury, over a 24 hour period, I am in pain:

☐ Less than 1 hour	☐ 1–4 hours	☐ 4–8 hours	☐ 8–16 hours	☐ 16–24 hours	

Modifying Factors

What makes the pain better?	What makes the pain worse?

Associated Symptoms: When you are having pain in this area, what else bothers you?
(examples: light-headedness, nausea, shortness of breath, feeling depressed, difficulty concentrating)
Other?:

Body Part:						
Pain Quality:	☐ burning	☐ shooting	☐ tingling	☐ radiating	☐ numbing	☐ cramping
	☐ achy	☐ throbbing	☐ pressure	☐ squeezing	☐ dull	☐ deep

Pain Severity: **Minimal** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Severe**

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SYMPTOM QUALITIES

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Modifying Factors

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Associated Symptoms: When you are having pain in this area, what else bothers you?
(examples: light-headedness, nausea, shortness of breath, feeling depressed, difficulty concentrating)
Other?:

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PAIN MEDICATION

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

Please list all prescribed medications that you are currently taking and the dosage.

Medications for Pain

Medication	Dose	How taken (# of pills & when)	If side effect, please describle

Medications for Other Conditions

Medication	Dose	How taken (# of pills & when)

Pain Response to Pain Medication (since last visit) ☐ Not Applicable

Regarding your OVERALL levelof pain:	**Response (1–10)**
What has your average pain level been?	
What is the intensity of your pain before you take your medication?	
What is the intensity of your pain after you take your medication?	
What is your current level of pain?	
	(# of minutes or hours)
After taking your pain medication, how long does it take for your pain to decrease?	
How long does the pain relief last?	

Functional Response to Pain Medications ☐ Not Applicable

With regard to function, has the pain medication:

1. Improved your ability to move? ☐ Yes ☐ No
2. Improved your ability to adhere to a home exercise program? ☐ Yes ☐ No
3. Improved your ability to have a social life? ☐ Yes ☐ No
4. Improved your ability to take an active part in family life? ☐ Yes ☐ No
5. Improved your tolerance for work functions and/or activities of daily living? ☐ Yes ☐ No
   If yes, describe:

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REVIEW OF SYSTEMS

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

1. Please check the "Yes" box to indicate if you have any of the following symptoms.
2. For any "Yes" responses, please check the "related" box if you believe the symptom is related to your work-related condition.
   NOTE: If nothing has changed since last visit, all you need to do is check this box: ☐

Constitutional	**Yes**	**Related**
Weight loss	☐	☐
Weight gain	☐	☐
Fevers	☐	☐
Chills	☐	☐
Night sweats	☐	☐
Fatigue	☐	☐
Falling asleep during the day	☐	☐
Eyes	**Yes**	**Related**
Blurry vision	☐	☐
Eye pain	☐	☐
Discharge	☐	☐
Dry eyes	☐	☐
Decreased vision	☐	☐
Ears / Nose / Throat	**Yes**	**Related**
Sore throat	☐	☐
Ringing in ears	☐	☐
Bloody nose	☐	☐
Hearing loss	☐	☐
Sinusitis	☐	☐
Respiratory	**Yes**	**Related**
Shortness of breath	☐	☐
Cough	☐	☐
Coughing up blood	☐	☐
Wheezing	☐	☐
Chest pain with breathing	☐	☐
Cardiovascular	**Yes**	**Related**
Chest pressure	☐	☐
Awake short of breath	☐	☐
Heart racing, extra beats	☐	☐
Ankles swelling	☐	☐
Shortness of breath lying flat	☐	☐
Chest tightness with exertion	☐	☐
Gastrointestinal	**Yes**	**Related**
Difficulty swallowing	☐	☐
Heartburn	☐	☐
Nausea/vomiting	☐	☐
Rectal bleeding	☐	☐
Abdominal pain	☐	☐
Skin or eyes turning yellow	☐	☐
Change in bowel habits	☐	☐
Loss of control of bowels	☐	☐
Allergy	**Yes**	**Related**
Sneezing fits	☐	☐
Frequent runny nose	☐	☐
Watery / Itchy eyes	☐	☐

Genitourinary	**Yes**	**Related**
Urinary frequency	☐	☐
Urination during sleep	☐	☐
Painful urination	☐	☐
Difficulty starting stream	☐	☐
Blood in urine	☐	☐
Loss of bladder control	☐	☐
Musculoskeletal	**Yes**	**Relate**
Joint pain	☐	☐
Stiffness	☐	☐
Joint swelling	☐	☐
Muscle weakness	☐	☐
Redness of joint(s)	☐	☐
Skin	**Yes**	**Related**
Rash	☐	☐
Itching	☐	☐
Open sores	☐	☐
Nail changes	☐	☐
Lesions	☐	☐
Neurologic	**Yes**	**Related**
Numbness	☐	☐
Paralysis / Inability to move	☐	☐
Changes in taste	☐	☐
Tremors	☐	☐
Unable to walk normally	☐	☐
Headaches	☐	☐
Dizziness	☐	☐
Light-headedness	☐	☐
Loss of consciousness	☐	☐
Endocrine	**Yes**	**Related**
Often thirsty	☐	☐
Frequent urination	☐	☐
Cold intolerance	☐	☐
Heat intolerance	☐	☐
Swelling in front of neck	☐	☐
Psychiatric	**Yes**	**Related**
Depression	☐	☐
Anxiety	☐	☐
Stress	☐	☐
Alcohol use	☐	☐
Illicit drug use	☐	☐
Unable to sleep	☐	☐
Blood and Lymphatic	**Yes**	**Related**
Easy bruising > 4 cm	☐	☐
Blood clots	☐	☐
Swollen glands (groin/armpit)	☐	☐

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MEDICAL, SURGICAL AND LIFESTYLE HISTORY, ADDITIONAL INFORMATION

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

Medical & Surgical History

Since your last visit, has anything changed regarding your medical or surgical history? ☐ Yes ☐ No

If yes, please specify:

Lifestyle / Social History

Since your last visit, has anything changed regarding your lifestyle / social history? ☐ Yes ☐ No

If yes, please specify:

Additional Information

If you have any additional information you wish to provide, please use the space below:

I declare that, to the best of my knowledge and belief, the information given above is correctly recorded complete and true.

Patient or Legal Guardian (print)	Signature	Date

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