BAYLOR Institute for Rehabilitation
Outpatient Services

Physiatric Medicine Associates
Baylor-Health Texas Affiliate
Baylor Tom Landry Center • 411 N. Washington Avenue
Suite 5000 • Dallas, TX 75246
214-820-8557 main • 214-820-9689 fax

New Patient History Intake Form

Patient Name: _____Sex: ❑ M ❑ F **DOB**: ___/___/___ **AGE**: _____

What is the reason for your visit? _____

Who referred you to our office? _____ Primary Care Physician: _____

When did this problem begin? _____

Describe your problem? _____

_____

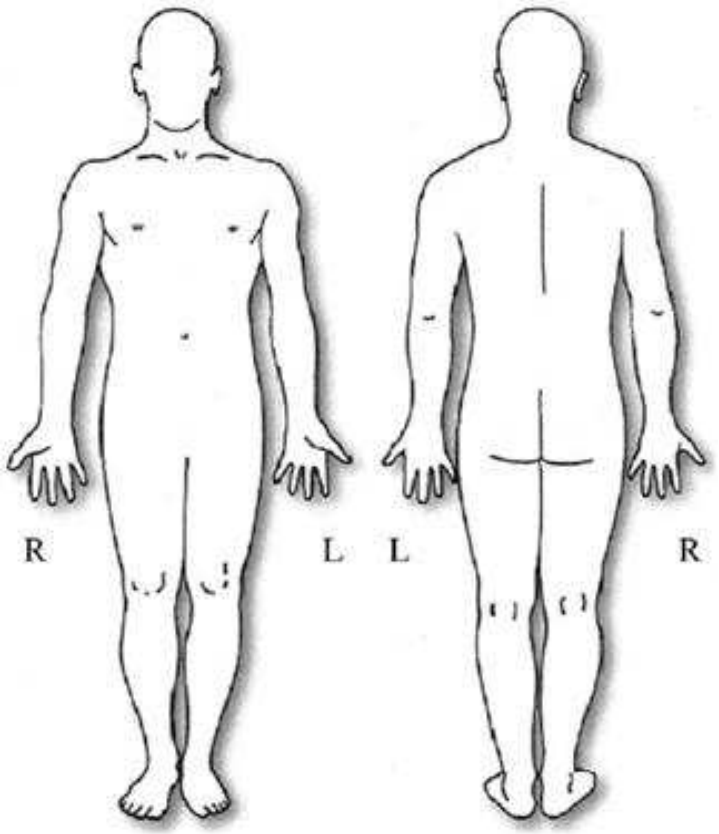
Are you having any pain associated with this problem? ❑ YES ❑ NO

Rate your PAIN on a scale of 1-10.

*1 being least amount of pain and 10 being the **worst** pain you have ever felt in your life.*

1 2 3 4 5 6 7 8 9

Use VERTICAL lines | | | to indicate **pain**
Use HORITZONTAL lines == to indicate **numbness or tingling**



FRONT BACK

Check ALL that apply in regards to pain.

❑ burning ❑ numbness ❑ pins & needles
❑ tingling ❑ dull ❑ sharp
❑ stabbing ❑ throbbing ❑ localized
❑ aching ❑ radiating ❑ shooting
❑ pressure ❑ grinding ❑ constant
❑ intermittent (*every now & then*)

Is your pain better/worse with the following:

Activity	Better?	Worse?
Sitting		
Standing		
Walking		

Review of Systems

Check ALL that apply.

❑ Weight loss/gain ❑ Fever
❑ Night Sweats ❑ _____

❑ Double Vision ❑ Blind Spots

❑ Ringing in Ears ❑ Vertigo/ Dizziness

❑ Shortness of Breath: ❑ At rest ❑ With activity
❑ Chest Pain

❑ Abdominal Pain ❑ Constipation
❑ Incontinence (*Loss of control of Bowel Movements*)
❑ Incontinence (*Loss of control of Urine*)
❑ Sexual Problems

❑ Pressure Sores ❑ Rash

❑ Easy Bruising ❑ Bleeding disorder

❑ Heat / Cold Intolerance ❑ Diabetes

❑ Anxiety/ Depression ❑ Difficulty Sleeping
❑ Falls ❑ _____

❑ Irritability ❑ Lack of concentration
❑ Cognitive Problems ❑ Difficulty Speaking
❑ Spasm of muscles ❑ Behavioral Problems

❑ Stress in personal life: _____

❑ Any chance that you are pregnant? _____

Describe in detail any checked boxes above:

_____

_____

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PAST MEDICAL AND SURGICAL HISTORY: *Please check the boxes of problems you have/ had.*

❑ Heart or blood vessel disease	❑ Foot or Leg Ulcer	❑ HIV/AIDS
❑ High/Low Blood Pressure	❑ Osteoporosis	❑ Cancer
❑ Lung Disease	❑ Arthritis	❑ Bleeding or clotting disorder
❑Liver Disease or Hepatitis	❑ Spine Surgery	❑ Depression or mental health
❑ Gastric Ulcers	❑ Spine and/or Steroid Injections	❑ Prior EMG/NCS
❑ Kidney Disease	❑ Seizures	❑ Prior Therapy
❑ Diabetes	❑ Stroke	❑ Surgeries:_____

❑ Other:_____

❑ Allergies to Medications:_____

SOCIAL HISTORY

❑ Student ❑ Single ❑ Married ❑ Divorced/separated ❑ Widowed Occupation: _____

Use Tobacco products? ❑ Yes Packs/day:_____ Use Alcohol? ❑ Yes ❑ No Year Quit:_____
❑ No ❑ Year Quit:_____ ❑ Socially How Often:_____

Problems with drug or substance use/dependency? ❑ Yes ❑ No ❑ Previously

If yes, please list:_____

Exercise regularly? ❑ Yes ❑ No Type:_____ How Often:_____
Use a cane/walker/wheelchair at home? ❑ Yes ❑ No Need assistance for self care? ❑ Yes ❑ No
Use a cane/walker/wheelchair outside of home? ❑Yes ❑ No
❑ Single Level Home ❑ Multiple Level Home

FAMILY HISTORY

❑Cancer ❑Heart Disease ❑Diabetes ❑Arthritis ❑Spine disorders ❑High Blood Pressure ❑Stroke
❑Mental Health Issues ❑Other:_____

Patient/ Representative: _____ Relationship: _____Date:_____

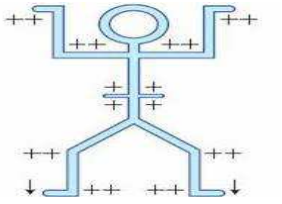
OFFICE USE ONLY:

TEMP: _____ BP: ____/___ HR: _____ Respirations _____ HT:_____ WT: _____lbs.

Appearance: Mood: Orientation:

	Head/Neck	Spine	L UE	L LE	R UE	R LE
Inspect/palpate						
ROM, SLR						
Motor						
Sensory						

Reflexes Gait Coordination Edema



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Home Medication List

Date:_____

Patient Name:_____ **DOB:**_____
Medication Allergies (Please list.):_____
Pharmacy Name:_____ **Pharmacy #:**_____

Name of Medication	Dose (example: mg, g, mcg, puffs, drops)	When do I take this medicine?					Why do I take it?
		AM	Noon	PM	Bed-time	With Food	
Over-the-Counter Medicines (*such as herbals, vitamins, antacids, aspirin*)							

Note: *You will be asked about any new medications upon each office visit by our staff. Medication verification prior to each visit is a National Patient Safety measure which is done in an effort to provide you with the very best care and it ensures that each member of your health care team has a an up-to-date, and accurate medical history.*