**PATIENT INTAKE FORM**

**Name**

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**What is your primary complaint or concern?**

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**When did this start?**

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**How did this start?**

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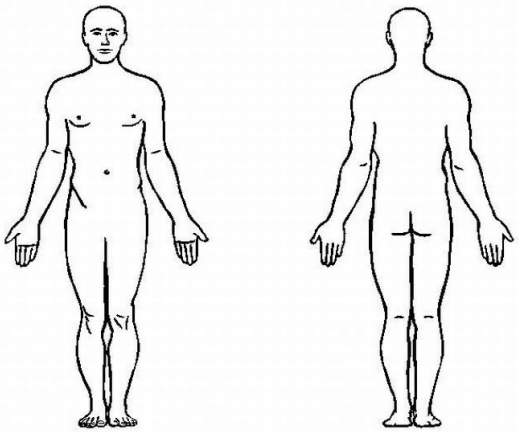
**Please draw your symptoms and describe your symptoms, and indicate whether they are intermittent or constant**



**If you have pain, please rate your pain level**

**Current pain level**


**The best your pain has been in the last week**


**The worst your pain has been the last week**


**PLEASE COMPLETE THE OTHER SIDE**

**When are your symptoms worst?**

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise/work ❑ N/A

**When are your symptoms the best?**

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise ❑ N/A

**What makes your symptoms worse?**

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**What makes your symptoms better?**

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**What other treatments have you tried to address these symptoms, and were they helpful?**

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**Have you had anything similar or related before?**

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**Do you have any other significant, related medical history, i.e surgeries, health issues etc?**

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**What diagnostic tests or imaging have been performed for this problem/concern?**

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**What are your normal activities of daily living?**

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**Of these normal activities, is there anything you are unable to do now because of your problem/concern?**

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**Are you getting ❑ Better ❑ Worse ❑ Staying the same?**

**What are your goals in coming to Biosports?**

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**When do you see your physician next?**

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