Kinect

**Confidential Medical History Intake Form**

Patient Name:_____ Ref. MD:_____

DOB:_____ Height:_____ Weight:_____ lbs

Email Address:_____Best Contact Phone #: (_____)_____

Mailing Address:_____City:_____State/Zip:_____

Emergency Contact:_____ Phone:(___)_____Relationship:_____

Chief Complaint:_____ Date of Onset/Injury:_____

Is This Visit Related to Work Injury: Y N

Is This Visit Related to Car Accident: Y N

Have You Received Any Diagnostic Testing For This Injury? X-Ray MRI CT-SCAN

Please List All Medications You Are Taking For This Problem:_____

_____

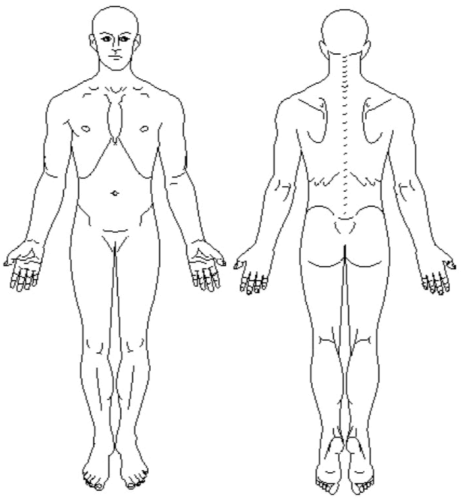
Please Circle if You Have Had or Are Currently Diagnosed With Any of The Following:

__Alzheimer's/Dementia
__Cardiovascular Disease/Chest Pain
__Cerebrovascular Accident (TIA/Stroke)
__Current Infection
__Diabetes Mellitus Type 1/Type 2
__DVT/PE/Blood Clot
__Fibromyalgia
__Frequent/Severe Headaches
__High Cholesterol
__High Blood Pressure
__History of Cancer
__Immunosuppression
__Lupus
__Osteoarthritis
__Osteoporosis/Osteopenia
__Parkinson's Disease
__Pacemaker
__Rheumatoid Arthritis
__Shortness of Breath
__Traumatic Brain Injury
Are you currently pregnant? Y N

Allergies/Other:_____

_____

On the Diagram below, please indicate the area where you are currently experiencing pain or other symptoms by marking those areas with an X on the diagram.



**<u>Rate your pain level in the past week using the scales below (0=no pain, 10=severe pain)</u>**

PAIN LEVEL AT WORST: 0 1 2 3 4 5 6 7 8 9 10

CURRENT PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

PAIN LEVEL AT BEST: 0 1 2 3 4 5 6 7 8 9 10

How would you describe your symptoms? (Mark all that apply)

__Dull/aching __Sharp/stabbing __Burning Other:_____