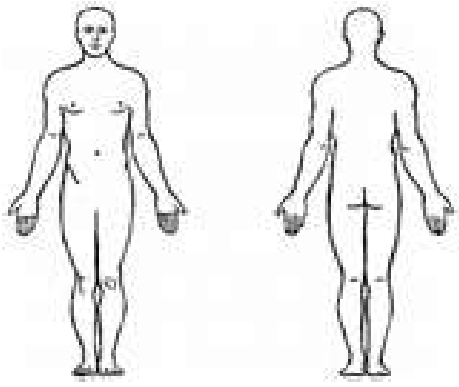
Hoffmann Sport and Spine Therapy
8 Anoka Avenue Unit 2
Barrington RI 02806
401-289-2444
Fax: 1-866-744-5975

New Patient Intake Form

Name:_____ Date: _____
DOB:_____Address_____
Phone#:H_____C_____Email:_____
Occupation:_____
Referral:_____
Is this condition: Job related MVA Acute Chronic Other_____



Chief Complaint:_____
Rate Pain level: 0 1 2 3 4 5 6 7 8 9 10 (0-None 10-Very Severe Pain)
Other Complaints:_____
Rate Pain level: 0 1 2 3 4 5 6 7 8 9 10 (0-None 10-Very Severe Pain)
When did the pain begin: ___/___/___ Prior Treatment:_____

Frequency: Constant Frequent Occasional Intermittent Daily/Weekly

Quality: Dull Sharp Throbbing Burning Deep Aching Tingling
Stabbing Cramping Numbness Radiation Other_____

Aggravating: Sitting Standing Walking Bending Stooping Lifting
Sleeping Sneezing Coughing Straining Reaching Twisting
Looking up Looking down Movement Rest Lying Down
Driving Typing House Chores Exercises Other_____

Relieving Factors: Sitting Standing Lying Knees bent up Support
No movement Movement Heat Ice Analgesic cream
Exercise Adjustments Medication_____

Other Information:
_____
_____

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Health History

Other Diagnosis: _____

_____

Trauma/MVA:_____

Medications:_____

Allergies:_____

Cancer:_____

Recent blood work:_____

Surgeries:_____

_____

Hospitalizations:_____

Exercise:_____

Nutritional Supplements:_____

Smoking/Alcohol:_____

Family History:_____

_____

Primary Physician:_____

Other Physicians:_____

_____

Your signature below will verify that all information you have given is accurate and complete.

Patient Signature:_____ Date:_____

Doctor Signature:_____ Date:_____