North Canyon Medical Center
Orthopedic Clinic
267 N. Canyon Dr. Gooding, ID 83330
Phone: (208) 934-5237 Fax: (208) 934-4874

NEW PATIENT INTAKE FORM

Date: _____

Patient Last Name: _____ First_____ Middle_____

Date of Birth: _____ Gender: Male: _____ Female: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

May we leave a voicemail message? ❑ Yes ❑ No

If yes, select type of message: ❑ Brief ❑ Extended

What are you being seen for today? (Only mark 2 body parts per office visit.)

O Neck	O Right Shoulder	O Left Wrist	O Right Knee	O Left Ankle
O Mid Back	O Left Shoulder	O Right Hand	O Left Knee	O Right Foot
O Low back	O Right Elbow	O Left Hand	O Right Calf/Leg	O Left Foot
O Ribs	O Left Elbow	O Right Hip/Thigh	O Left Calf/Leg	Other: _____
	O Right Wrist	O Left Hip/Thigh	O Right Ankle	_____

How long have symptoms been present or date of injury: _____

How did the pain occur? O Injury O Ongoing Problem O Spontaneous

Is this work related? O Yes O No

Briefly describe your injury and/or pain:

_____

_____

_____

Pain Description: (CIRCLE ANSWER)

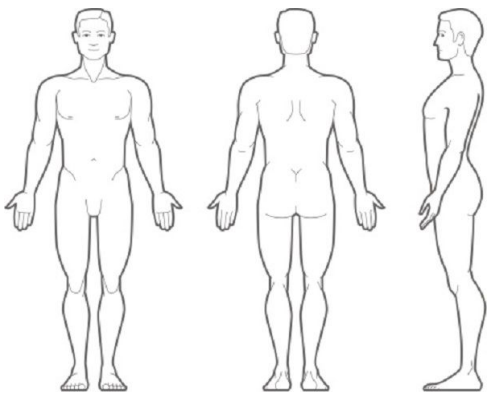
What is the quality of your pain? **Mild / Moderate / Severe**

How would you describe your pain? **Sharp / Dull / Burning**

Have you had physical/occupational therapy? **Yes / No**

Have you been treated elsewhere for this problem? **Yes / No**

If yes, where and by whom? _____



Are you taking any Medications for this problem?

☐ Narcotic (Vicodin, Codeine, etc.) ☐ Anti-inflammatory (Advil, Motrin, etc.) ☐ Muscle Relaxer (Flexeril, Soma, etc.)
☐ Steroid / Steroid Injections

Have you had any of the following diagnostic tests for the problem you are being seen for today? (Please circle answer)

X-Ray MRI EMG/NCS Bone Scan CT Scan Bone Density Test

Allergies to medications? ***None*** □ ***What happens?***

Medications List ***None*** □

Name of Medication	***Strength/Dosage***	***How many times a day do you take it?***

Please attach another paper if needed

Medical History – Have you ever had the following?

O Osteoporosis	O High Blood Pressure	O Diabetes	O Thyroid Disease
O Arthritis	O Heart Disease	O Cancer	O DVT/Pulmonary Embolism
O Poor Circulation	O Irregular Heart Beat	O Anemia	O Asthma
O Epilepsy/Seizures	O Heart Attack	O Kidney Disease	O Emphysema/COPD
O Stroke	O Seizures	O Anemia/ Bleeding problems	

Other : _____

Infectious Diseases

O Tuberculosis O Lyme Disease O Hepatitis O MRSA

Please list other infectious diseases you have been diagnosed with: _____

Family History: **Father: Living □ Deceased □ How old when he passed away and why? _____**

Mother: Living □ Deceased □ How old when she passed away and why? _____

Has anyone in your family had a heart attack? Yes No If So, who? _____.

Surgical History and Dates:

_____

_____.

Occupation: Employed □ Unemployed □ Retired □ Homemaker □ Disabled □ Student □

If employed what is your type of work? _____

Activity Status: Athletic □ Active/Fit □ Occasionally/Rarely □ Never □ Ideal body weight for you_____

Tobacco Products/Nicotine: Cigarettes □ Cigars □ Smokeless/Chew □ E-cigarette/ Vape □ None□

Currently use□ How many per day_____ How many years smoked_____ Quit□ Quit Date_____

Alcohol Use: Daily □ Weekly □ Socially □ Rarely □ Beer □ Wine □ Hard Alcohol □ None □

Caffeinated Products: Coffee # /day____ Tea #/day____ Soda Pop #/day____ Energy Drink #/day____

Illegal Drugs: Marijuana□ Methamphetamines □ Cocaine□ Other_____ None□

Experimented with □ Currently Use □ Quit □ When did you quit_____ Rehabilitation □ Self Recovery □

Mental Health: **N/A**□ Depression □ Anger Problems □ Bipolar □ Cutting □ Other_____

Not treated □ Treated □ If treated, Dr. name _____

Communicable Diseases: **NA**□ Measles □ Mumps □ HIV/AIDS □ Hepatitis □ A □ B□ C□

Other_____

Code Status: **Full Code**- All lifesaving measures □ **DNR**-Do Not Resuscitate □

I would like to talk to the doctor about this? Yes: _____ No: _____

Which pharmacy do you use?: _____**City/State:** _____

Patient Signature_____ ***Date***_____