JAMES J. NICHOLSON, MD
NEW PATIENT INTAKE FORM

Please circle or write in response

Patient: ________________ Home phone number: ______________
MRN: __________________ Age ____ Gender M/F
DOS: ___________________ Height ____ Weight_____lbs

Patient seen at the request of:
Doctor's name____________________
address____________________
phone number ______________

Problem:

History of Problem:

Describe the onset/trauma

Describe changes over time

Location Hip Front/Back/Inner/Outer/Groin
Knee Front/Back/Inner/Outer/knee cap
Other: ____________________
Character: Sharp/Aching/Burning/Tight/Stiff
Pain score at rest 0 1 2 3 4 5 6 7 8 9 10 (0 for no pain, 10 for worst pain imaginable)
Pain score with activity0 1 2 3 4 5 6 7 8 9 10
What increases the pain?: Rest/Walking/Stairs/Sitting/Pivot-Twist/Run
Does it radiate? Y/N Where? ______________
Catching? Y/N When? ______________ Freq ______________ Painful Y/N
Locking? Y/N When? ______________ Freq ______________
Buckling? Y/N When? ______________ Freq ______________
What medications have you tried? ______________
What alleviates it? ______________
Activities given up? ______________

Amount of Pain: none / slight / mild / moderate / marked / disabling
Distance Walked: unlimited / 1 mile / 6 blocks / 2-3 blocks / indoors only / unable to walk
Support needed: none / 1 cane for long walks / 1 cane full time / 1 crutch / 2 canes / unable
Limp: none / slight / moderate / severe
Sitting: comfortable any chair 1 hour / comfortable high chair 1 hour / unable to sit comfortably
Stairs: step over step unsupported / need banister for support / one step at a time difficult / unable

JAMES J. NICHOLSON, MD
NEW PATIENT INTAKE FORM

Socks/Ties shoes: with ease / with difficulty / unable
Transportation: get in and out independently / significant difficulty
Arise form chair: with arms / without arms

Past Surgical History:

Past Medical History:

Allergies:

Medications:

Social History:

Marital Status M/D/W/S
Occupation _______________ Currently working Y/N
Tobacco ____(packs/day)____years Alcohol (rarely/occasionally/daily)
Illicit Drugs _______________

Family History:

__Cancer __Cardiac/MI __Pulmonary
__Endocrine/diabetes __Hypertension __Problems with anesthesia
__Bleeding Issues __History of joint replacement

Review of Systems:

__Cancer __Recent weight loss/gain __Neurologic
__Pulmonary __Cardiac/MI __Diabetes/thyroid
__Bowel/bladder __Gout/RA __Bleeding/clotting disorders
__Use of rheumatoid arthritis medications __Problems with anesthesia
__Chronic use of oral steroids or cancer medications

Did you attend one of our Hip and Knee Pain Seminars? Y/N

Location ________________ Date _______________

JAMES J. NICHOLSON, MD
NEW PATIENT INTAKE FORM

Did you see one of our newspaper advertisements? Y/N
Newspaper _______________ Date ______________

Thank you for taking the time to fill out this questionnaire, it will help us take better care of you today.

I have personally reviewed this intake form on the day of service listed ________________(Dr. Sig)