MendelsonKornblum
Orthopedic & Spine Specialists
11900 East 12 Mile Ste 110 / Warren, MI 48093

Shoulder Intake Form

Date: _____________

Patient Name:
Patient ID #

Birth date: Age: Gender: Male Female

Who referred you to us?
- ☐ Hospital program
- ☐ Insurance referral
- ☐ Internet/Website
- ☐ Friend/family Name:
- ☐ Physician referral
- ☐ Advertisement

Primary Care Physician:_________________________________
Phone #:( ) -
Referring Physician:_________________________________
Phone #:( ) -
Pharmacy Location_________________________________
Phone #:( ) -

What shoulder has the problem? ☐ Left ☐ Right | Is this your dominant arm? ☐ Yes ☐ No

Height: Weight:

Please check all that apply:
- ☐ Auto accident injury
- ☐ Injury on the job
- ☐ Legal proceedings pending
- ☐ Working with a rehab nurse
- ☐ Receiving disability income
- ☐ Receiving workers comp.
- ☐ Had previous neck or shoulder surgery

Do you have an attorney or case manager? ☐ Yes ☐ No

If yes, please give the name and phone number:

Describe the onset of your shoulder problem, give an approximate date.

When did the injury occur:

Where did it occur:

Explain what happened:

Rate the pain on a scale of 1 (mild pain) through 10 (unbearable pain) :

Check if you have experienced any of the following:
- ☐ Shoulder dislocation or coming out of the joint
- ☐ Instability of popping out of place of the shoulder
- ☐ Waking in the middle of sleep because of the pain

What activities can't you do because of your condition?
- ☐ Put on your coat
- ☐ Comb your hair
- ☐ Do usual sports
- ☐ Lift > 10 lbs. over shoulder
- ☐ Reach high shelf
- ☐ Manage toileting
- ☐ Do usual work
- ☐ Sleep on your painful side
- ☐ Wash back
- ☐ Hook up bra in back

What makes the pain better?
☐ Lying down ☐ Physical Therapy ☐ Ice ☐ Pain Pills ☐ Muscle Relaxers ☐ Rest ☐ Bathing/Shower
Other: ____

Check any prior treatments:
- ☐ Taken any pain medication
- ☐ Seen Chiropractor
- ☐ Seen Pain Physician
- ☐ Had Physical Therapy
- ☐ Had injection in the shoulder
- ☐ Seen Neurologist
- ☐ Seen Orthopedic Surgeon

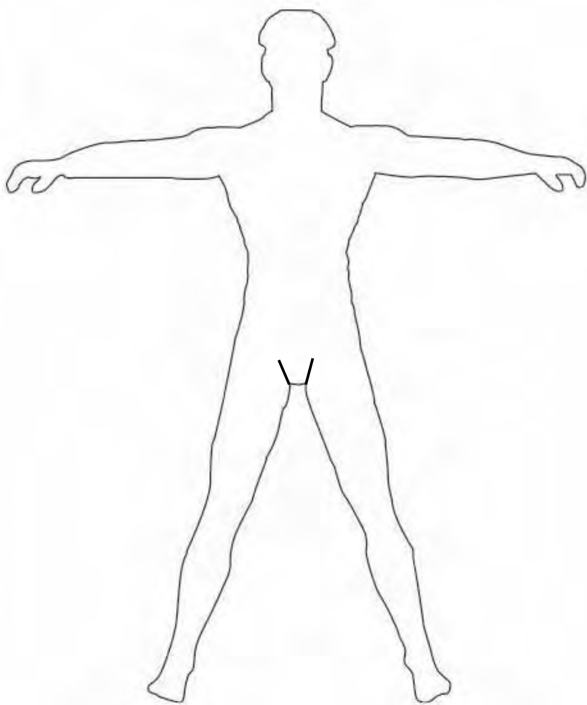
Have you had previous studies such as?
☐ MRI ☐ CAT Scan ☐ EMG Needle Study ☐ Bone Scan ☐ Xrays ☐ Ultrasound ☐ Blood Work
Other (explain): ____

Pain Assessment

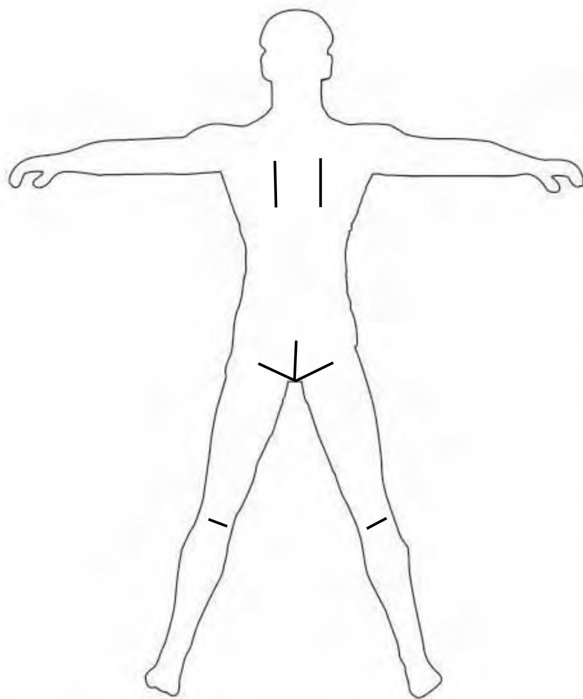
Mark these drawings according to where you hurt. If the back of your neck hurts, mark the drawing on the back of the neck, etc. If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram. If markings are not applicable, indicate areas of pain in your own words below.

Symptom	Mark
Numbness	------------
Pins and Needles	00000
Burning	x x x x x
Ache	~ ~ ~ ~ ~
Stabbing	/ / / / /

FRONT



BACK



Additional Comments:

Medical History

Past Medical History: Have you ever had any of the following: Check all that apply, provide explanation in space below.

☐ AIDS/HIV	☐ Blood Transfusions	☐ High Blood Pressure	☐ Neurological Disease
☐ Anxiety/Depression	☐ Cancer	☐ High Cholesterol	☐ Pacemaker
☐ Arthritis	☐ Diabetes	☐ Kidney Disease	☐ RSD
☐ Autoimmune Disorder	☐ Fibromyalgia	☐ Liver Disease/Hepatitis	☐ Stomach Ulcer
☐ Bleeding Disorder	☐ Gout	☐ Lung Disease	☐ Stroke
☐ Blood Clots	☐ Heart Disease	☐ Major Infection	☐ Thyroid Disease

Please explain:

Family History

Mother	Father
Living: ☐ Yes ☐ No ☐ Unknown. Diseases: ☐ No known significant family history ☐ Unknown ☐ Significant (add below)	Living: ☐ Yes ☐ No ☐ Unknown. Diseases: ☐ No known significant family history ☐ Unknown ☐ Significant (add below)

Are you Jehovah's Witness? ☐Yes ☐No Are you willing to accept blood/blood products? ☐Yes ☐No

Surgical History

Month/Year	Orthopedic	Month/Year	General
Have you ever had a reaction to anesthesia?	☐ Yes	☐No	

Social History

Occupation/Employer: ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children __________

Do you smoke/use tobacco? ☐ Yes ☐ No How much? ______________________________

Did you in the past? ☐ Yes ☐ No How long? ___________Date you quit: _________

Do you drink alcohol? ☐ Yes ☐ No Type/Weekly amount_______________________

Did you in the past? ☐ Yes ☐ No Type/Weekly amount_______________________

Allergies (Drug)

Allergic to	Reaction
Are you allergic to Latex? ☐ Yes ☐ No	Can you take aspirin? ☐ Yes ☐ No

Medications **Pain**

Medication	Dose	Frequency		Medication	Dose	Frequency
				Vit/Supp	Dose	Frequency

Review of Symptoms

Indicate "yes" or "no" to any symptoms you have had in recent months. Indicate which symptoms you have had if multiple symptoms are listed.

Symptom	Yes	No
Skin rash, sore, or excessive bruising?		
Numbness or tingling?		
Fever, night sweats, or chills?		
Frequent nosebleeds?		
Cough, shortness of breath, wheezing, or asthma?		
Chest pain or pressure?		
Exposed to anyone with tuberculosis?		
Blacked out, lost consciousness or had a seizure?		
Abnormal swelling of legs or feet?		
Pain in the calves of your legs when you walk?		
Change in bowel or bladder habits? (ie. incontinence)		
Pain, stiffness, or swelling in your joints or back?		
Do you feel you are at risk for HIV or AIDS?		
Muscle weakness?		
Dizziness or falling?		
Travel outside the US?		

Who do you authorize us to speak to regarding your medical care? Please list below:

Name	Relationship

E-Signature of Patient____ Date: _________________
Patient Legal Representative (if applicable)__________________________ Date: _________________
Print name of Legal Representative ______________________________ Relationship: ___________

Billing Information Form

Patient Last Name	Patient First Name	MI
Mailing Address		
City	State	Zip Code
Home Phone	Cell Phone	Work Phone
Email Address	Date of Birth	Social Security Number
Emergency Contact	Relationship	Contact's Phone ☐ Home ☐ Cell ☐ Work

Responsible Party

Last Name	First Name

Is this an auto or work comp? ☐ Worker Comp ☐ Auto

Claim # ________________________________ Date of Injury: ________________________

Insurance Carrier: ____

Adjuster's Name: ____

Phone #: ____

Do you have an attorney? ☐ Yes ☐ No

Attorney Name: ____

Attorney's Phone #: ____

Primary Insurance Coverage	Subscriber	Gender ☐ M ☐ F	DOB:
Contract/ID Number	Group/Policy Number	Relationship: ☐ Self ☐ Spouse ☐ Dependent	
Secondary Insurance Coverage	Subscriber	Gender ☐ M ☐ F	DOB:
Contract/ID Number	Group/Policy Number	Relationship: ☐ Self ☐ Spouse ☐ Dependent	