MOTION IS MEDICINE
SPORTS MEDICINE

DANIEL A. CLEARFIELD, DO, MS, FAOASM
SPORTS MEDICINE & NON-OPERATIVE ORTHOPEDICS
OSTEOPATHIC MANIPULATIVE MEDICINE
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(817) 900-3539
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NEW PATIENT INTAKE FORM

Please answer all questions on both pages. Circle answers where indicated.

Name: _____ **Date of Birth:** _____/_____/_____ **Age:** _____

Referred by: _____ **Ref office #:** _____ **Ref fax #:** _____

PCP: _____ **PCP office #:** _____ **PCP fax #:** _____

What are you seeing Dr. Clearfield for today? _____

When did the problem/injury begin? _____ **Which side?** left right both midline

How did this problem/injury occur (if known): _____

What makes it worse? _____

What makes it better? _____

For this condition have you had any: X-Rays MRI CT scan Nerve/muscle studies MSK Ultrasound Injections

Physical Therapy Medications Prescribed Other tests/treatments: _____

Have you had this injury/problem before? Yes / No **If yes, dates of occurrence:** _____

Is this injury/problem work or school related? Yes / No **Hand dominance:** Left handed Right handed Ambidextrous

What sports do you play? _____ **What school?** _____

What is your normal activity level? Very Active Slightly Active Relatively Inactive Sedentary

Have there been changes in your activity level or training over the course of your injury? Yes / No

Type of sporting activity: Recreational / Competitive **Number of sports/teams currently playing on:** _____

What are your current concerns and/or your goals regarding your injury/problem?

_____

Past medical history (ie: high blood pressure, high cholesterol, diabetes, heart attack, cancer, stroke, DVT, COVID, etc):

_____ _____ _____

_____ _____ _____

Past surgical history (if not already stated above; list dates as well):

_____ _____ _____

_____ _____ _____

Medications taking (including over-the-counter, supplements):

_____ _____ _____

_____ _____ _____

Allergies (drug, tape, shellfish, or dyes): Yes / No **If yes, to what?** _____

Are you up to date on your preventive screening exams (ie: mammogram, pap smear, colonoscopy)? Yes / No

Are you up to date on your immunizations/vaccines (ie: tetanus, COVID-19)? Yes / No

Tobacco use? Yes / No **How long have you been using tobacco?** ___ years **Are you ready to quit?** Yes / No

Alcohol use? Yes / No **Illicit substance use?** Yes / No If yes, then list:_____ **Caffeine use?** Yes / No

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Highest level of education:_____ **Occupation/School Grade:**_____

Marital status: Single / Married / Divorced / Widowed **Kids (ages)** _____

Who lives at home with you? _____ **Hobbies:**_____

Family History (please specify family member effected: mother, father, sister, maternal grandmother etc.):

Osteoarthritis _____
Rheumatoid arthritis _____
High blood pressure _____
Diabetes _____
Heart disease/heart attack _____
Thyroid disease _____
Cancer (type, age diagnosed) _____
Autoimmune disease _____
Ankylosing spondylitis _____
Other _____

Review of Systems (please circle if you have been <u>currently</u> experiencing any of the following):

CONSTITUTIONAL:
Chills
Fatigue
Fever
Night Sweats
Weakness
Unexplained Weight Loss

EYES:
Blurred Vision
Vision Loss
Glaucoma

ENMT:
Headache
Hearing Loss
Nosebleeds
Difficulty Swallowing

CARDIOVASCULAR:
Poor Circulation
Rheumatic Fever (history)
Chest Pain
Heart Murmur
Leg Swelling
Syncope/Passing Out
Irregular Heartbeat/ Palpitations

RESPIRATORY:
Cough
Wheezing
Shortness of Breath on Exertion
Sleep Apnea

GASTROINTESTINAL:
Abdominal Pain
Constipation
Diarrhea
Heartburn
Loss of Appetite
Nausea/Vomiting
Leaking of Bowel Movement
Ulcers
Hepatitis

GENITOURINARY:
Frequent Urination
Hematuria (blood in urine)
Urinary Incontinence

MUSCULOSKELETAL:
Arthritis
Fractures
Stress Fractures
Sprains

NEUROLOGICAL:
Difficulty walking
Dizziness
Poor coordination
Falls
Memory Loss
Muscle Weakness
Numbness/Paresthesias
Seizures
Tremors
Neuropathy

SKIN AND/OR BREAST:
Contact Dermatitis
Rash
Skin Infection

PSYCHIATRIC:
Anxiety
Depression
Schizophrenia
Bipolar Disorder
Suicidal Thoughts

ENDOCRINE:
Diabetes
Thyroid Disease
Gout
Osteoporosis
Vitamin D Deficiency

HEMATOLOGICAL:
Anemia
Bleeding Disorder
Easy Bruising
HIV/ AIDS
Sickle Cell
Cancer

ALLERGIC/IMMUNOLOGICAL:
Environmental allergies
Food allergies
Seasonal allergies

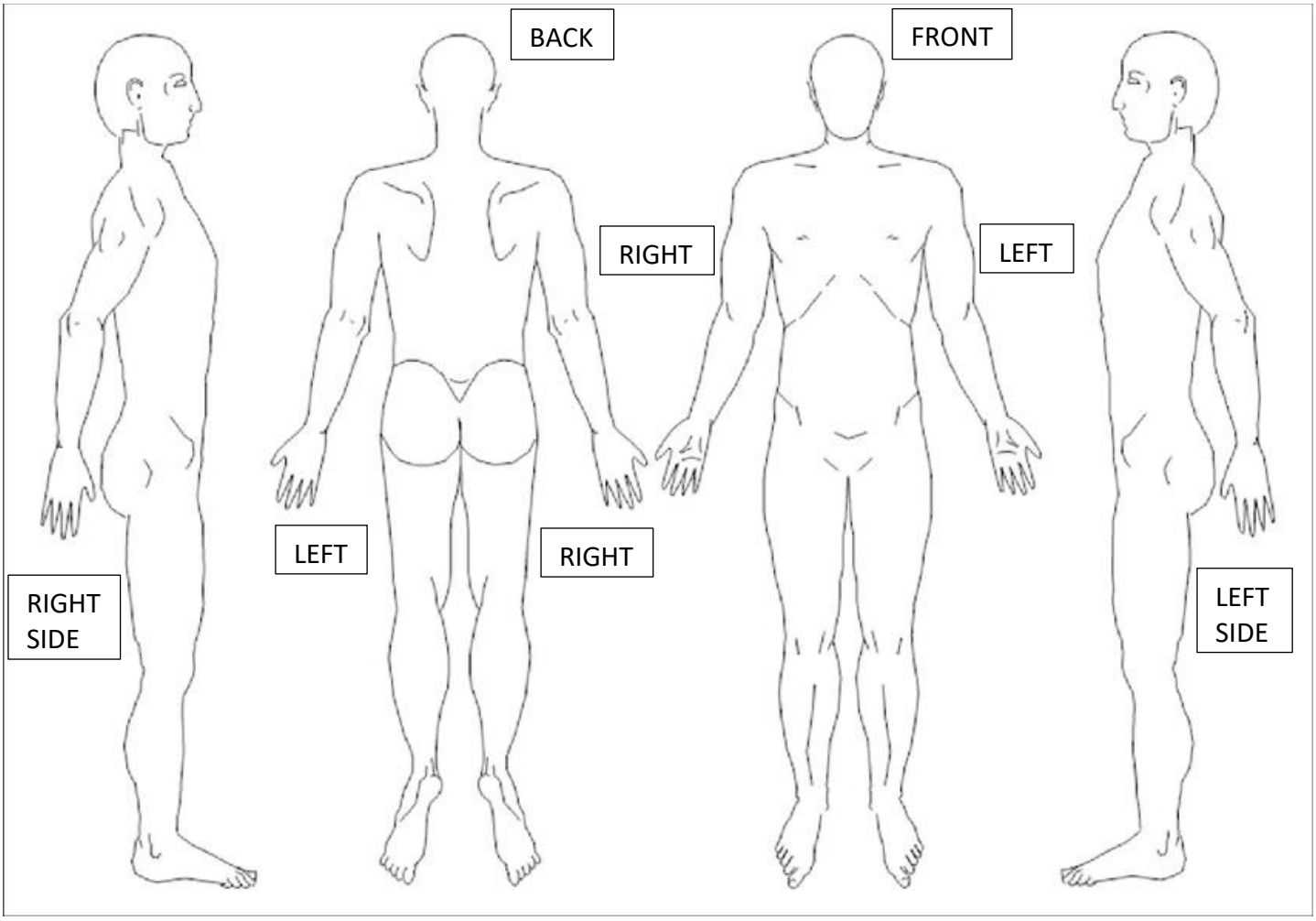
Patient Signature: _____ **Date:** _____/_____/20_____

Physician Reviewed _____ Date _____/_____/20_____ Physician Reviewed _____ Date _____/_____/20_____

Physician Reviewed _____ Date _____/_____/20_____ Physician Reviewed _____ Date _____/_____/20_____

BODY PAIN DIAGRAM

If applicable to you, please mark the area(s) you are experiencing your pain



Pain Intensity:

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

No pain — Moderate pain — Arms literally being torn off pain

Type of Pain:

☐ Aching ☐ Dull ☐ Throbbing ☐ Sharp ☐ Burning ☐ Numbness ☐ Tingling

☐ Shooting ☐ Radiating ☐ Other: _____

Duration of Pain:

☐ Constant ☐ Most of Time ☐ Comes & Goes ☐ Once in a While ☐ Hardly Ever

☐ Other: _____

Patient Signature: _____ Date:___/___/20___