University Hospitals
Case Medical Center

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General Intake Form

First Name _____ Last Name _____ Date ____ / ____ / ____

☐ Male Occupation _____ Email address: _____

☐ Female

May we send you information or follow-up surveys at this email address? ☐ Yes ☐ No

Date of Birth ____ / ____ / ____ Age ____

Height ____ft ____in Weight _____ What extremity is bothering you? ☐ Knee ☐ Elbow ☐ Shoulder ☐ Other: _____

Who referred you to us?

Name _____

Address _____

Would you like a letter sent to the person who referred you?
Yes No

Who is your Internist or Primary Care Physician?

Name _____

Address _____

Would you like a letter sent to your physician?
Yes No

Is a legal case involved with this injury? ☐ Yes ☐ No

Is this a work related injury? ☐ Yes ☐ No **(If No, please skip to MEDICAL HISTORY, page 2.)**

Job title _____

How long have you worked for your current employer? ____ years (If less than 1 year ____ months)

Are you:
☐ Off Work
☐ Modified Duty
☐ Full Duty

If you are not working full duty, what date did you last do so?
____ / ____ / ____

When you work, you experience:
☐ No limitations
☐ Mild limitations
☐ Moderate limitation
☐ Severe limitations
☐ Not working

Select the best description of any change you have had in work activities since your injury/surgery. Your work activities have:

☐ **Not Changed**
If yes, check one below:
☐ I have no/slight problems
☐ I have moderate/significant problems

☐ **Decreased**
If yes, check one below:
☐ I now have no/slight problems
☐ I have moderate/ significant problems
☐ For reasons not related to my injury

☐ **Unable to Work**
If yes, check one below:
☐ I have moderate/significant problems when I work
☐ For reasons not related to my injury

Are you on or planning to apply to any of the following programs?

	Already on it	Applied for it	Planning to apply for it
Social Security	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Worker's Compensation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If your problem is work related, check the response which best describes what you actually do at work **when working full duty. Check** only **one** response in each column.

Sitting	Standing/ Walking	Walking on Uneven Ground	Squatting	Climbing	Lifting/ Carrying	Pounds Carried
☐ 0 hr/day	☐ 0 hr/day	☐ 0 hr/day	☐ 0 times/day	☐ 0 times/day	☐ 0 times/day	☐ 0-5 lbs
☐ 1 hr/day	☐ 1 hr/day	☐ 1 hr/day	☐ 1-5 times/day	☐ 1 flight, 2 times/day	☐ 1-5 times/day	☐ 6-10 lbs
☐ 2-3 hrs/day	☐ 2-3 hrs/day	☐ 2-3 hrs/day	☐ 6-10 times/day	☐ 3 flights, 2 times/day	☐ 6-10 times/day	☐ 11-20 lbs
☐ 4-5 hrs/day	☐ 4-5 hrs/day	☐ 4-5 hrs/day	☐ 11-15 times/day	☐ 10 flights/ ladders	☐ 11-15 times/day	☐ 21-25 lbs
☐ 6-7 hrs/day	☐ 6-7 hrs/day	☐ 6-7 hrs/day	☐ 16-20 times/day	☐ Ladders with weight 2-3 days/week	☐ 16-20 times/day	☐ 26-30 lbs
☐ 8-10 hrs/day	☐ 8-10 hrs/day	☐ 8-10 hrs/day	☐ More than 20 times/day	☐ Ladders daily with weight	☐ More than 20 times/day	☐ More than 30 lbs

MEDICAL HISTORY

Are you currently or have you ever had problems with the following:

	Yes	No	Describe all "YES" responses
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Lung/Breathing Problem	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Ulcer or Stomach Problem	☐	☐	_____
Kidney Problem	☐	☐	_____
Hepatitis	☐	☐	_____
Anemia or other Blood Disorder	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____
Anxiety/Depression	☐	☐	_____
Arthritis/Rheumatoid Arthritis	☐	☐	_____
Thyroid Problem	☐	☐	_____
Other medical condition	☐	☐	_____

Please list all medications you currently use with dosage and frequency (don't forget vitamins, over-the-counter, and herbal medications):

Do you have any medication allergies? ☐ Yes ☐ No

If yes, please list:

Have you ever had problems with general anesthesia? ☐ Yes ☐ No

How many surgeries have you had on your affected joint? ____

Please list all past surgeries and hospitalizations:

Surgery/Hospitalization	Date	Physician

FAMILY HISTORY

Does your immediate family (mother, father, sisters or brothers) have a history of any of the following medical conditions?

	Yes	No
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Cancer	☐	☐

SOCIAL HISTORY

Race:
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Asian
- ☐ Other

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced/Separated
- ☐ Widowed

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much per week? _____

Do you smoke? ☐ Yes ☐ No

If yes, how many packs per day? _____

How long have you smoked? _____

Thank you for completing this form!