Integrated Health, PC

Initial Evaluation Form

Copay: ___________

Collected: ___________

COVID-19 Checklist: Fever: Y N Cough: Y N Shortness of Breath: Y N COVID-19 Exposure: Y N

Date: _______________ Name: ____ Age: ________

Chief Complaint / Reason for visit: ____

____

When did symptoms begin: ________________ Symptoms began as a result of ______________________

____

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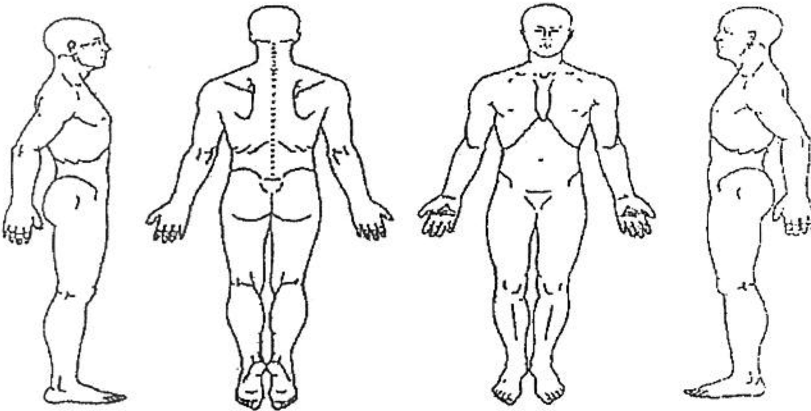
Please mark location of symptoms on body diagram:



Circle discomfort level

0= none 10= worst imaginable

At its best: 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

Please describe symptoms: ____

Are symptoms constant or intermittent? If intermittent, how often and when? ____________________

Do symptoms affect sleep? Y N

What aggravates your symptoms? ____

How do symptoms affect your activities and/ or job? ____

What medicine(s) are you taking for symptoms? ____

Imaging performed? ☐ MRI ☐ X-ray ☐ CT ☐ Other ______________________

____

Other medical conditions, medications and surgical history: ________________________________

____

Have you had any falls in the past 12 months? Y N

If yes, were there any injuries? ____