Patient Intake Form

Patient information		**Referring MD Information**	
Name		Name	
Address		Address	
City/ State/ Zip		City/State/Zip	
DOB			
Home Phone		Telephone	
Cell Phone		Fax	
Email			
Insurance information			
Carrier			
ID#			
Group #			
Name of Insured			
DOB of Insured			

AMERICAN HIP INSTITUTE Of Chicago

INFO@AMERICANHIPINSTITUTE.COM
999 E. TOUHY AVE SUITE 450
DES PLAINES, IL 60018
(630) 920-2323

Medical Record Review Questions

Where is your pain located?

_____

How long has your pain been present? Did you have an injury? If yes, please describe.

_____

Do you or have you taken NSAIDS or any other medication for relief? Please list medications taken for your current condition.

_____

Have you had physical therapy specific to your condition?
If yes, how many visits? Did you have relief?

_____

Have you had any injections for your current condition?
If yes, please describe what type. Did you have relief? For how long?

_____

Have you had previous surgery for your current condition?
If yes, please describe what type. Did you have relief? For how long?

_____

Have you had any imaging studies for your current condition? X-RAY, MRI, CT, etc.
If yes, please describe what type, dates performed.

_____

INFO@AMERICANHIPINSTITUTE.COM
999 E. TOUHY AVE SUITE 450
DES PLAINES, IL 60018
(630) 920-2323