PATIENT INTAKE FORM

Patient Name:_____ Date:_____

1. **Indicate below the area(s) and intensity of your pain/symptom(s)**

AREA	INTENSITY (scale of 1-10; 10 being the worst)
1_____	_____
2_____	_____
3_____	_____
4_____	_____
5_____	_____

2. **How often do you experience your symptoms?**
   - ○ Constantly (76-100% of the time)
   - ○ Occasionally(26-50% of the time)
   - ○ Frequently (51-75% of the time)
   - ○ Intermittently (1-25% of the time)

3. **How would you describe the type of pain?**

○ Sharp	○ Burning	○ Sharp with motion
○ Dull	○ Shooting	○ Shooting with motion
○ Diffuse	○ Stabbing	○ Stabbing with motion
○ Achy	○ Numb	○ Electric like with motion
○ Stiff	○ Tingly	○ Other_____

4. **How are your symptoms changing with time?**
   ○ Getting Worse ○ Staying the Same ○ Getting Better

5. **How much has the problem interfered with your work?**
   ○ Not at all ○ A little bit ○Moderately ○ Quite a bit ○ Extremely

6. **How much has the problem interfered with your social activities?**
   ○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

7. **Who else have you seen for your problem?**

○ Chiropractor	○ Neurologist	○ Primary Care Physician
○ ER Physician	○ Orthopedist	○ Other:_____
○ Massage Therapist	○ Physical Therapist	○ No one

8. **How long have you had this problem?**
   _____

9. **How do you think your problem began?**
   _____

10. **Do you consider this problem to be severe?**
    ○ Yes ○ Yes, at times ○ No

11. What aggravates your problem(s)?

○ Always there	○ Neck Movement	○ Sitting
○ Coughing	○ Reaching	○ Standing
○ Sneezing	○ Lifting	○ Walking
○ Straining at the stool	○ Bending	○ Stairs
○ Exercising	○ Twisting	○ Driving
○ Breathing Deeply	○ Sleeping/Lying	○ Other_____

12. What concerns you the most about your problem; what does it prevent you from doing?_____

13. What is your: Height_____ Weight:_____ Age:_____
Occupation_____

14. How would you rate your overall Health?

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

15. What type of exercise do you do?

○ Strenuous ○ Moderate ○ Light ○ None

16. Indicate if you have any immediate family members with any of the following:

○ Rheumatoid Arthritis	○ Diabetes	○ Lupus
○ Heart Problems	○ Cancer	○ ALS

17. For each of the following conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
○	○ Headaches	○	○ High Blood Pressure	○	○ Diabetes
○	○ Neck Pain	○	○ Heart Attack	○	○ Excessive Thirst
○	○ Upper Back Pain	○	○ Chest Pains	○	○ Frequent Urination
○	○ Mid Back Pain	○	○ Stroke	○	○ Smoking/Tobacco Use
○	○ Low Back Pain	○	○ Angina	○	○ Recreation Drugs
○	○ Shoulder Pain	○	○ Kidney Stones	○	○ Alcohol Dependence
○	○ Elbow/Arm Pain	○	○ Kidney Disorders	○	○ Allergies
○	○ Wrist Pain	○	○ Bladder Infection	○	○ Depression
○	○ Hand Pain	○	○ Painful Urination	○	○ Systemic Lupus
○	○ Hip Pain	○	○ Loss of Bladder Control	○	○ Epilepsy
○	○ Upper Leg Pain	○	○ Prostate Problems	○	○ Eczema/Rash
○	○ Knee Pain	○	○ Abnormal weight loss/gain	○	○ HIV/AIDS
○	○ Ankle/Foot Pain	○	○ Loss of Appetite		
○	○ Jaw Pain	○	○ Abdominal Pain	**For Females Only**	
○	○ Joint Pain/Stiffness	○	○ Ulcer	○	○ Birth control pills
○	○ Arthritis	○	○ Hepatitis	○	○ Hormone Therapy
○	○ Rheumatoid Arthritis	○	○ General Fatigue	○	○ Pregnancy
○	○ Cancer	○	○ Liver/Gallbladder Disorder		
○	○ Tumor	○	○ Muscular Incordination		
○	○ Asthma	○	○ Visual Disturbances		
○	○ Chronic Sinusitis	○	○ Dizziness	○	○Other_____

18. List all prescription medications you are currently taking:

_____

_____

19. List all of the over-the-counter medications/supplements you are currently taking:

_____

20. List all surgical procedures and dates in the past 5-6 years:

_____

_____

21. What activities do you do at work? ○ Not Applicable

○ **Sit:**	○ Most of the day	○ Half the day	○ A little of the day
○ **Stand:**	○ Most of the day	○ Half the day	○ A little of the day
○ **Computer work:**	○ Most of the day	○ Half the day	○ A little of the day
○ **On the phone:**	○ Most of the day	○ Half the day	○ A little of the day

22. What activities/hobbies do you do outside of work?

_____

23. Have you ever been hospitalized in the past 5-6 years? ○ Yes ○ No

If yes, why and dates_____

_____

24. Have you had significant past trauma? ○ Yes ○ No

If yes, explain:_____

_____

25. Anything else pertinent to your visit today?_____

Patient Signature_____ Date_____

Notes:_____

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