## **PATIENT INTAKE FORM**

Patient Name:	Date:		
1. Is today's problem caused by:   Auto Accident	□ Workman's Compensation		
2. Indicate on the drawings below where you have	ve pain/symptoms		
3. How often do you experience your symptoms?			
<ul><li>□ Constantly (76-100% of the time)</li><li>□ Frequently (51-75% of the time)</li></ul>	□ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)		
4. How would you describe the type of pain?			
□ Sharp □ Numb □ Dull □ Tingly □ Diffuse □ Sharp with motion □ Achy □ Shooting with □ Burning □ Stabbing with □ Shooting □ Electric like wi □ Stiff □ Other:	motion		
<b>5. How are your symptoms changing with time?</b> □ Getting Worse □ Staying the Same	□ Getting Better		
<b>6. Using a scale from 0-10 (10 being the worst),</b> h 0 1 2 3 4 5 6 7 8 9 10 ( <i>Ple</i>	now would you rate your problem? ease circle)		
7. How much has the problem interfered with you   Not at all A little bit Moderately	ur work? □ Quite a bit □ Extremely		
8. How much has the problem interfered with you  □ Not at all □ A little bit □ Moderately	ur social activities?  Quite a bit □ Extremely		
9. Who else have you seen for your problem?  □ Chiropractor  □ Reurologist  □ Corthopedist  □ Massage Therapist  □ Physical Therapist	□ Primary Care Physician □ Other: □ No one		
10. How long have you had this problem?			
11. How do you think your problem began?			
12. Do you consider this problem to be severe?  Yes Yes, at times No			
13. What aggravates your problem?			
14. What concerns you the most about your prob	olem; what does it prevent you from doing?		
15. What is your: Height Weight	t Age		
Occupation			
<b>16.</b> How would you rate your overall Health?  □ Excellent □ Very Good □ Good □ Fa	air □ Poor		
17. What type of exercise do you do?  □ Stenuous □ Moderate □ Light	□ None		

<b>18. Indicate if you have any imm</b> □ Rheumatoid Arthritis □ Heart Problems	nediate	family members with any □ Diabetes □ Cancer	[	following: □ Lupus □ ALS		
19. For each of the 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	_	□ Drug/Alcohol Dependance		
□ □ Shoulder Pain		□ Kidney Stones		□ Allergies		
□ □ Elbow/Upper Arm Pain		□ Kidney Disorders		□ Depression		
□ □ Wrist Pain		□ Bladder Infection		□ Systemic Lupus		
□ □ Hand Pain		□ Painful Urination		□ Epilepsy		
□ □ Hip Pain		□ Loss of Bladder Contro	l 🗆	□ Dermatitis/Eczema/Rash		
□ □ Upper Leg Pain		□ Prostate Problems		□ HIV/AIDS		
□ □ Knee Pain		□ Abnormal Weight Gain/	Loss			
□ □ Ankle/Foot Pain		□ Loss of Appetite		or Females Only		
□ □ Jaw Pain		□ Abdominal Pain		□ Birth Control Pills		
□ □ Joint Pain/Stiffness		□ Ulcer		□ Hormonal Replacement		
□ □ Arthritis		□ Hepatitis		□ Pregnancy		
□ □ Rheumatoid Arthritis		□ Liver/Gall Bladder Diso	rder			
□ □ Cancer		□ General Fatigue				
□ □ Tumor		□ Muscular Incoordination	า			
□ □ Asthma		□ Visual Disturbances				
□ □ Chronic Sinusitis		□ Dizziness				
□ □ Other:						
20. List all prescription medications you are currently taking:  21. List all of the over-the-counter medications you are currently taking:						
22. List all surgical procedures you have had:						
23. What activities do you do at work?						
	of the			□ A little of the day		
	t of the o	•	•	□ A little of the day		
	of the			□ A little of the day		
□ On the phone: □ Most	t of the o	day □ Half of th	ne day	□ A little of the day		
24. What activities do you do outside of work?						
25. Have you ever been hospitalized? □ No □ Yes if yes, why						
26. Have you had significant past trauma? □ No □ Yes						
27. Anything else pertinent to your visit today?						
Patient Signature		Date	::			