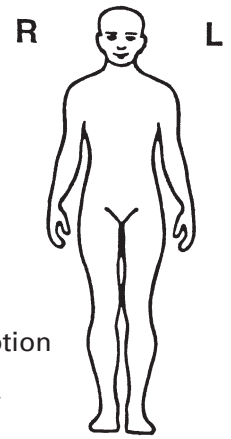
PATIENT INTAKE FORM

Patient Name: _____ Date:

1. Is today's problem caused by: ❑ Auto Accident ❑ Workman's Compensation ❑ Other

2. Indicate on the drawings to the right where you have pain/symptoms →



3. 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)

4. How would you describe the time of pain?

❑ Sharp ❑ Dull ❑ Diffuse ❑ Achy

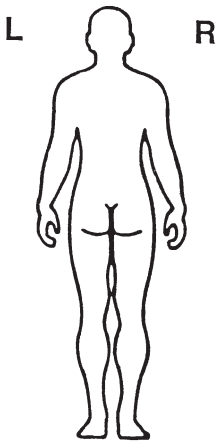
❑ Achy ❑ Burning ❑ Shooting ❑ Stiff

❑ Numb ❑ Tingly ❑ Sharp with motion ❑ Shooting with motion

❑ Electric-like with motion ❑ Other: _____

5. How are your symptoms changing with time?

❑ Getting Worse ❑ Staying the Same ❑ Getting Better



6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

1 2 3 4 5 6 7 8 9 10 *(please circle)*

7. How much has the problem interfered with your work?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

8. How much has the problem interfered with your social activities?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

9. Who else have you seen for your problem?

❑ Chiropractor ❑ Neurologist ❑ Primary Care Physician

❑ ER Physician ❑ Orthopedist ❑ No one

❑ Massage Therapist ❑ Physical Therapist ❑ Other:_____

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 alleviates your problem? _____

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

_____

16. What is your: Height_____ Weight_____ Date Birth_____

17. Occupation _____ Have you missed work?_____

18. How would you rate your overall Health?

❑ Excellent ❑ Very Good ❑ Good ❑ Poor

19. What type of exercise do you do?

❑ Strenuous ❑ Moderate ❑ Light ❑ None

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

❑ Rheumatoid Arthritis ❑ Diabetes ❑ Lupus

❑ Heart Problems ❑ Cancer ❑ ALS

20. 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 the 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 Dependence
❑	❑	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 Control	❑	❑	Dermatitis/Eczema/Rash
❑	❑	Upper Leg Pain	❑	❑	Prostate Problems	❑	❑	HIV/AIDS
❑	❑	Knee Pain	❑	❑	Abnormal Weight Gain/Loss			
❑	❑	Ankle/Foot Pain	❑	❑	Loss of Appetite	For Females Only		
❑	❑	Jaw Pain	❑	❑	Abdominal Pain	❑	❑	Birth Control Pills
❑	❑	Join Pain/Stiffness	❑	❑	Ulcer	❑	❑	Hormonal Replacement
❑	❑	Arthritis	❑	❑	Hepatitis	❑	❑	Pregnancy
❑	❑	Rheumatoid Arthritis	❑	❑	Liver/Gall Bladder Disorder			
❑	❑	Cancer	❑	❑	General Fatigue			
❑	❑	Tumor	❑	❑	Muscular Incoordination			
❑	❑	Asthma	❑	❑	Visual Disturbances			
❑	❑	Chronic Sinusitis	❑	❑	Dizziness			
❑	❑	Other:_____						

21. List all prescription medications you are currently taking:

_____

22. List all of the over-the-counter medications you are currently taking:

_____

23. List all surgical procedures you have had:

_____

24 What activities do you do outside of work?

_____

25. Have you ever been hospitalized? ❑ No ❑ Yes

If yes, why _____

27. Have you had significant past trauma? ❑ No ❑ Yes

28. Have you previously seen a chiropractor? ❑ No ❑ Yes

If yes, what were the results? ❑ Great ❑ Good ❑ Fair ❑ Mixed ❑ Poor ❑ Other

28. Anything else pertinent to your visit today? _____

Patient Signature_____ Date:_____