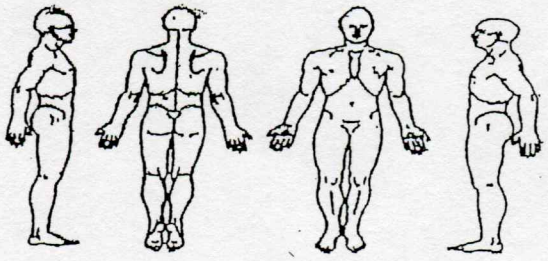
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

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

2. Indicate on the drawings below where you have 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 type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ 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?

0 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 □ Other:_____
□ Massage Therapist □ Physical Therapist □ 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?/ What alleviates your problem?

_____

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

_____

15. What is your: Height_____ **Weight** _____ **Age** _____
Occupation _____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

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

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ 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	
□	□	Headaches
□	□	Neck Pain
□	□	Upper Back Pain
□	□	Mid Back Pain
□	□	Low Back Pain
□	□	Shoulder Pain
□	□	Elbow/Upper Arm Pain
□	□	Wrist Pain
□	□	Hand Pain
□	□	Hip Pain
□	□	Upper Leg Pain
□	□	Knee Pain
□	□	Ankle/Foot Pain
□	□	Jaw Pain
□	□	Joint Pain/Stiffness
□	□	Arthritis
□	□	Rheumatoid Arthritis
□	□	Cancer
□	□	Tumor
□	□	Asthma
□	□	Chronic Sinusitis
□	□	Other:_____

Past	Present	
□	□	High Blood Pressure
□	□	Heart Attack
□	□	Chest Pains
□	□	Stroke
□	□	Angina
□	□	Kidney Stones
□	□	Kidney Disorders
□	□	Bladder Infection
□	□	Painful Urination
□	□	Loss of Bladder Control
□	□	Prostate Problems
□	□	Abnormal Weight Gain/Loss
□	□	Loss of Appetite
□	□	Abdominal Pain
□	□	Ulcer
□	□	Hepatitis
□	□	Liver/Gall Bladder Disorder
□	□	General Fatigue
□	□	Muscular Incoordination
□	□	Visual Disturbances
□	□	Dizziness

Past	Present	
□	□	Diabetes
□	□	Excessive Thirst
□	□	Frequent Urination
□	□	Smoking/Tobacco Use
□	□	Drug/Alcohol Dependance
□	□	Allergies
□	□	Depression
□	□	Systemic Lupus
□	□	Epilepsy
□	□	Dermatitis/Eczema/Rash
□	□	HIV/AIDS

For Females Only

Past	Present	
□	□	Birth Control Pills
□	□	Hormonal Replacement
□	□	Pregnancy

20. List all prescription medications/supplements you are currently taking:

_____

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

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do at work?

□ **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 of the 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?_____

28. Have you seen a Chiropractor before? _____ **if Yes last time seen** _____

Patient Signature_____ **Date:**_____