

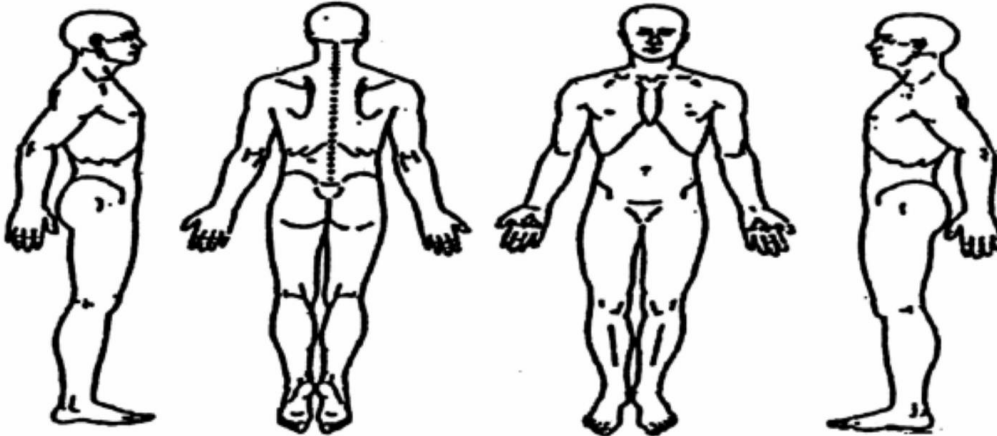
# PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident     Workman's Compensation     Major Medical/Self Pay

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?  
\_\_\_\_\_

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

15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_/\_\_\_\_

Occupation \_\_\_\_\_

16. How would you rate your overall Health?  
 Excellent     Very Good     Good     Fair     Poor

17. What type of exercise do you do?  
 Strenuous     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.

| <b>PAST</b>              |   | <b>PRESENT</b>           |  | <b>PAST</b>              |  | <b>PRESENT</b>           |  |
|--------------------------|---|--------------------------|--|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches            | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst        |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst        | <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination      |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain      | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains                 | <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination      | <input type="checkbox"/> | <input type="checkbox"/> Smoking/Tobacco Use     |
| <input type="checkbox"/> | <input type="checkbox"/> Mid Back Pain        | <input type="checkbox"/> | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> | <input type="checkbox"/> Smoking/Tobacco Use     | <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain        | <input type="checkbox"/> | <input type="checkbox"/> Angina                      | <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Dependence | <input type="checkbox"/> | <input type="checkbox"/> Allergies               |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain        | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones               | <input type="checkbox"/> | <input type="checkbox"/> Allergies               | <input type="checkbox"/> | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorders            | <input type="checkbox"/> | <input type="checkbox"/> Depression              | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus          |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain           | <input type="checkbox"/> | <input type="checkbox"/> Bladder Infection           | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus          | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain            | <input type="checkbox"/> | <input type="checkbox"/> Painful Urination           | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash  |
| <input type="checkbox"/> | <input type="checkbox"/> Hip Pain             | <input type="checkbox"/> | <input type="checkbox"/> Loss of Bladder Control     | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash  | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Leg Pain       | <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems           | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS                |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Knee Pain            | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Weight Gain/Loss   |                          |  | <b>For Females Only</b>  |  |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain      | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite            | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills     | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement    |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain              | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills     | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy               |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Ulcer                       | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement    |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy               |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder |                          |  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer               | <input type="checkbox"/> | <input type="checkbox"/> General Fatigue             |                          |  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Tumor                | <input type="checkbox"/> | <input type="checkbox"/> Muscular In-coordination    |                          |  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma               | <input type="checkbox"/> | <input type="checkbox"/> Visual Disturbances         |                          |  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis    | <input type="checkbox"/> | <input type="checkbox"/> Dizziness                   |                          |  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Other:_____          |                          |  |                          |  |                          |  |

20. List all prescription medications with dosage you are currently taking:  
\_\_\_\_\_  
\_\_\_\_\_

21. List all of the over-the-counter medications you are currently taking:  
\_\_\_\_\_

22. List all medication allergies:  
\_\_\_\_\_

23. List all surgical procedures you have had:  
\_\_\_\_\_

24. 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

25. What activities do you do outside of work?  
\_\_\_\_\_

26. Have you ever been hospitalized?     No     Yes  
if yes, why \_\_\_\_\_

27. Have you had significant past trauma?     No     Yes

28. Have you have seen a chiropractor before?     No     Yes    Past Experience?    Good    Fair    Poor

29. Anything else pertinent to your visit today? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_