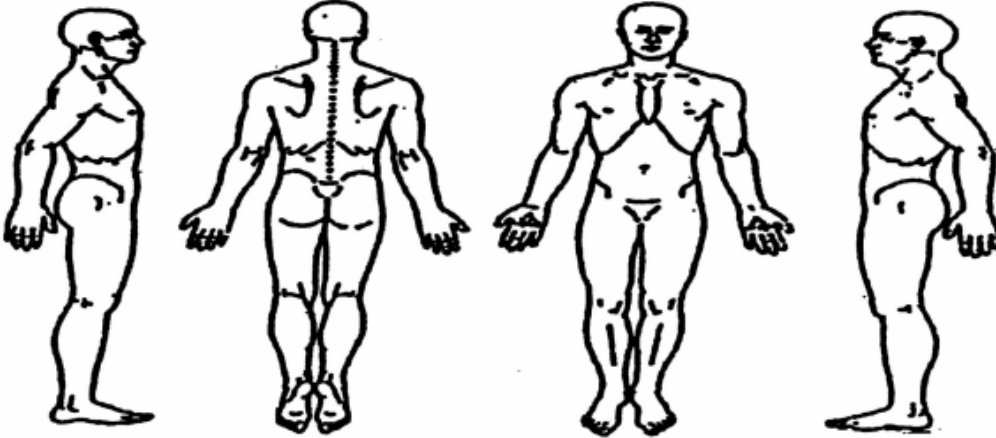


# PATIENT INTAKE FORM

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?  
\_\_\_\_\_

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

15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_  
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.

- | Past                     | Present                                       | Past                     | Present  | Past                     | Present  |
|--------------------------|---|--------------------------|--|--------------------------|--|
| <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"/> Neck Pain            | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst        |
| <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"/> 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"/> 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"/> Shoulder Pain        | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones               | <input type="checkbox"/> | <input type="checkbox"/> Allergies               |
| <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"/> Wrist Pain           | <input type="checkbox"/> | <input type="checkbox"/> Bladder Infection           | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus          |
| <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"/> 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"/> 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   |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain      | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite            |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain              | <input type="checkbox"/> | <b>For Females Only</b>                          |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Ulcer                       | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills     |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement    |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy               |
| <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 Incoordination     |                          |  |
| <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 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?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> 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 ever seen a chiropractor before?     No     Yes

27. Have you had significant past trauma?     No     Yes

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

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