

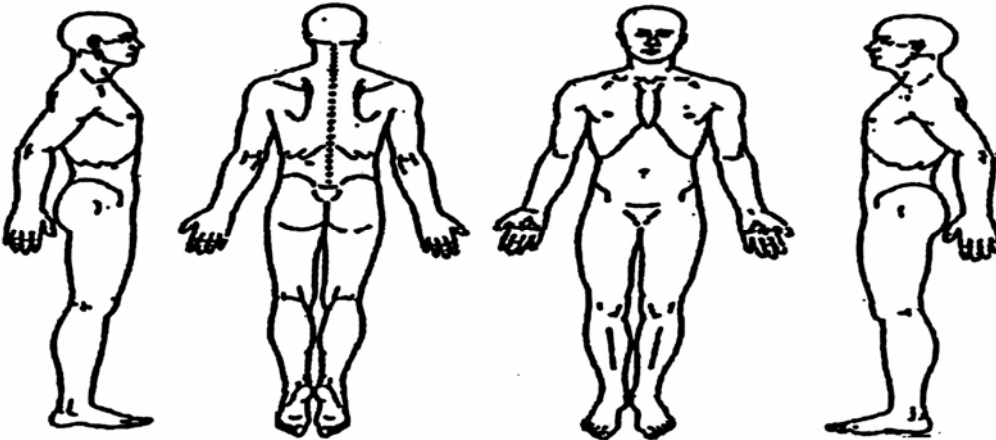
PATIENT INTAKE FORM

Patient Name: _____ Date: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ E-mail: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Single Married Other
 Have you ever had chiropractic care before? No Yes When? _____
 How did you hear about us? _____

1. Is today's problem caused by:

- Auto Accident Workman's Compensation Other

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 Not Changing 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?

- | | | |
|--|---|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> 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.a. What aggravates your problem?

13.b. What alleviates your problem?

14. What does your problem prevent you from doing?

15. What are your three goals for your chiropractic treatment?

16. What is your: Height _____ **Weight** _____ **Age** _____ **DOB** _____

Occupation _____



17. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

18. What type of exercise do you do?

- Strenuous Moderate Light None

19. 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 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
- Arm Pain
- Wrist Pain
- Hand Pain
- Upper Leg Pain
- Hip Pain
- Knee Pain
- Ankle/Foot Pain
- Jaw Pain
- Joint Swelling
- Arthritis
- Rheumatoid Arthritis
- General Fatigue
- Muscular Incoordination
- Visual Disturbances
- Dizziness

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
- Gall Bladder Problems
- Cancer
- A Tumor
- Asthma
- Chronic Sinusitis

Past Present

- Diabetes
- Excessive Thirst
- Frequent Urination
- Tobacco Use
- Drug/Alcohol Dependency
- Allergies
- Depression
- SLE
- Epilepsy
- Dermatitis
- HIV/AIDS

For Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy

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 of the nutritional supplements/vitamins you are currently taking:

24. List all surgical procedures you have had:

25. 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 |

26. What activities do you do outside of work?

27. Have you ever been hospitalized? No Yes if yes, why

28. Have you had significant past trauma? No Yes

29. Anything else pertinent to your visit today?

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____