

# PATIENT INTAKE FORM

KIRSTEIN CHIROPRACTIC LLC  
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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

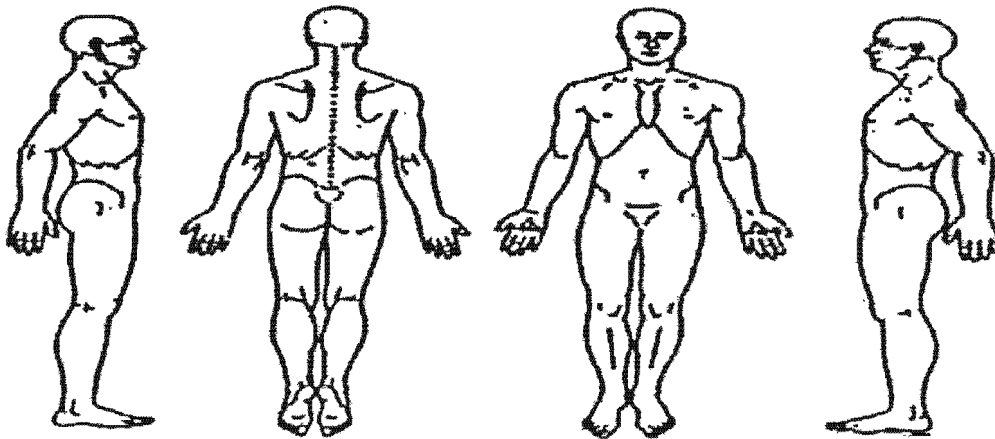
E-Mail Address: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Phone #: \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

1. Is today's problem caused by: \_\_\_Auto Accident\_\_\_ Workman's Comp \_\_\_Other

2. Indicate on the drawings below where you have pain/symptoms



3. Using a scale from 0-10 (10 being the worst), how would you rate EACH of your problems?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

Please indicate on the drawing: How you would rate EACH area of pain/symptoms?

4. How often do you experience your symptoms? Please indicate for EACH symptom.

- |   |   |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time)  |
| <input type="checkbox"/> Frequently (51-75% of the time)  | <input type="checkbox"/> Intermittently (1-25% of the time) |

5. How would you describe the type of pain for EACH problem?

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion         |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion      |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____              |

6. How are your symptoms changing with time? Please indicate for EACH symptom.

- Getting Worse                       Staying the Same                       Getting Better

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

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

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

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

9. Who else have you seen for EACH 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                 |

BY WHOM WERE YOU REFERRED? \_\_\_\_\_

WHO IS YOUR PRIMARY CARE DOCTOR? \_\_\_\_\_

Would you mind if we send your primary care doctor reports?                      YES                      NO

10. How long have you had EACH problem? \_\_\_\_\_

\_\_\_\_\_

11. How do you think EACH problem began?

\_\_\_\_\_

\_\_\_\_\_

12. Do you consider your problems to be severe?

- Yes                       Yes, at times                       No

If yes, which ones? \_\_\_\_\_

13. What aggravates EACH of your problems?

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14. What alleviates (helps) EACH of your problems?

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15. What concerns you the most about EACH of your problems; what does it prevent you from doing?

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16. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_  
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	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		<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: _____				

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 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
Drives:	Most of the day	Half of the day	A little of the day
Perform manual labor:	Most of the day	Half of the day	A little of the day
Reads alot:	Most of the day	Half of the day	A little of the day
Travels frequently:	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 seen a chiropractor before? No Yes

Who did you see and when? \_\_\_\_\_

What were the results of your treatment? great good fair mixed poor other

28. Have you had significant past trauma? No Yes

If yes, describe \_\_\_\_\_

29. Have you had a non fasting cholesterol test in the past five years?

If yes, when \_\_\_\_\_

30. Have you had an influenza vaccination this year? No Yes

If yes, when \_\_\_\_\_

31. Have you been screened for colon cancer? No Yes

If yes, when and what were the results \_\_\_\_\_

Females:

32. Are you up to date on your PAP SMEARS?

If yes, when and what were the results \_\_\_\_\_

Males:

33. Have you been screened for prostate problems? No Yes

If yes, when \_\_\_\_\_

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

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