PATIENT INTAKE FORM

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Patient Name: _____ Date: _____

Address:_____

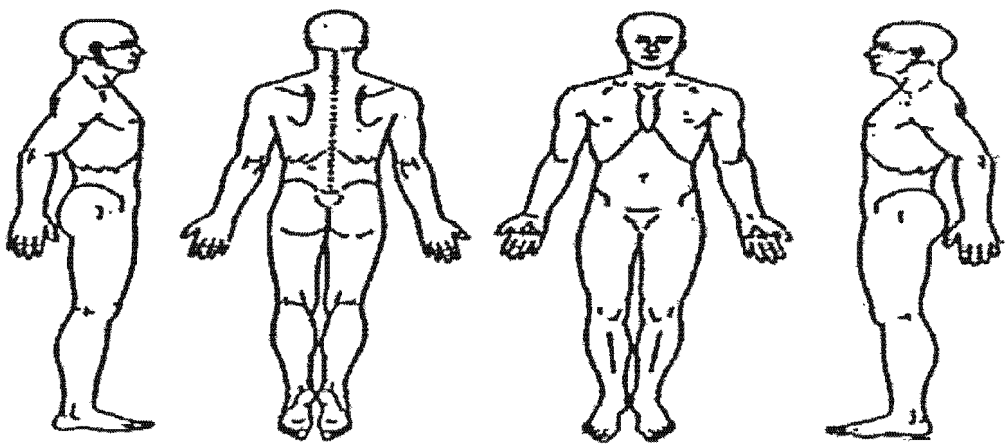
E-Mail Address:_____ D.O.B.:_____

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.

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)

□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

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

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

□ Chiropractor	□ Neurologist	□ Primary Care Physician
□ ER physician	□ Orthopedist	□ Other:_____
□ Massage Therapist	□ Physical Therapist	□ 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?

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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