

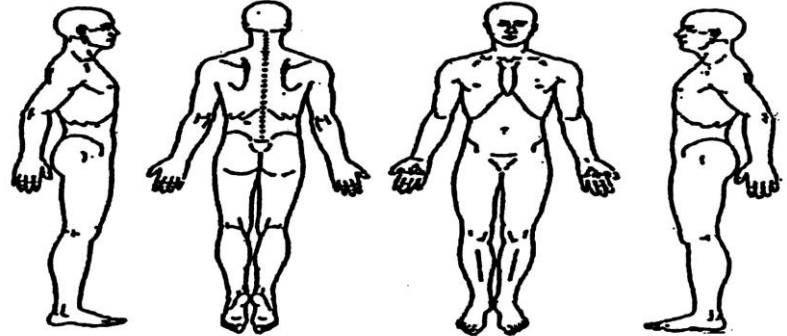
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

Primary Complaint: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation Other: _____

2. Place a circle on the drawings identifying the area(s) of complaint.



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

4. How would you describe the type of pain?

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

7. How much has the problem interfered with your work? Not at all Slightly Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities? Not at all Slightly Moderately Quite a bit Extremely

9. Who else have you seen for your problem? Chiropractor Neurologist Primary Care Physician ER physician
 Orthopedist Massage Therapist Physical Therapist No one Other: _____

10. How long have you had this problem? _____ Days Weeks Months Years

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? _____ What makes it better? _____

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

Secondary Complaint: _____

1b. How often do you experience your symptoms? Constantly (76-100% of the time) Frequently (51-75% of the time)
 Occasionally (26-50% of the time) Intermittently (1-25% of the time)

2b. How would you describe the type of pain?

- Sharp Numb Achy Shooting Shooting with motion Electric like with motion Stiff
- Tingly Burning Dull Diffuse Stabbing with motion Sharp with motion OTHER: _____

3b. How are your symptoms changing with time? Getting Worse Not Changing Getting Better

4b. Using a scale from 0-10 (10 being the worst), how would you rate your problem? _____

5b. How much has the problem interfered with your work? Not at all Slightly Moderately Quite a bit Extremely

6b. How much has the problem interfered with your social activities? Not at all Slightly Moderately Quite a bit Extremely

7b. Who else have you seen for your problem? Chiropractor Neurologist Primary Care Physician ER physician
 Orthopedist Massage Therapist Physical Therapist No one Other: _____

8b. How long have you had this problem? _____ Days Weeks Months Years

9b. How do you think your problem began? _____

10b. Do you consider this problem to be severe? Yes Yes, at times No

11b. What aggravates your problem? _____ What makes it better? _____

12b. 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	For Females Only	
<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"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness	Other	
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> _____
<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"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		

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 of the supplements you are currently taking:

23. 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? No Yes

27. Have you had significant past trauma? No Yes If yes, what? _____

28. Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____

