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**PATIENT INTAKE FORM** **CHART # _____**

Today's Date_____

First Name: _____Last Name:_____Middle Initial: _____

Address: _____

City:_____State:_____Zip_____Email_____

Date of Birth:_____ Age_____ Sex □ Male □ Female
Marital Status: □ Single □ Married □ Divorced □Widowed Social Security #_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Do you consent to receive text messages? □ Yes □ No

Primary Care Physician _____ Phone_____

**1. Is today's problem caused by:** □ Auto Accident □ Workman's Compensation □ Sports Injury

□ Slip & Fall □ On going issue □Flare up of previous condition □ Other _____

**Date of Injury:_____ Do you have an attorney? Y N**

**If yes, who is your attorney? _____ Firm:_____Phone: _____**

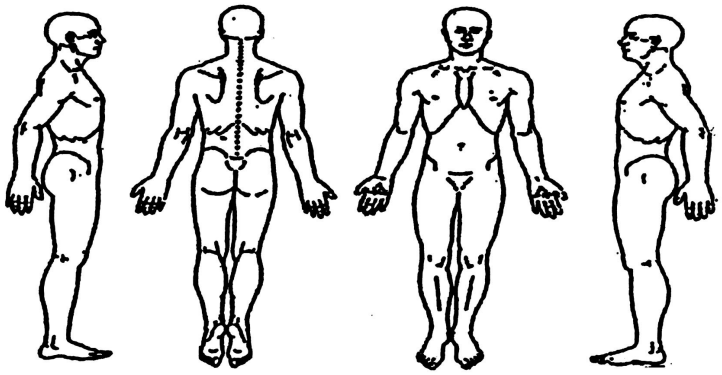
**Insurance Information:**

**Auto Insurance: _____**

**Policy#_____ Claim# _____**

**Health Insurance: _____ ID#_____Group#_____**

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



**3. How would you describe the type of pain?**

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

**4. 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)

**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

**Patient Name**_____

**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?** □ No □ Yes □ Yes, at times

**13. What aggravates your problem?**_____

**What alleviates your problem?** _____

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

_____

**15. What is your: Height**_____**Weight** _____**Occupation** _____

**16. What type of exercise do you do?** □ Strenuous □ Moderate □ Light □ None

**17. 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 Dependence |
| □ | □ | 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 | □ | □ | Osteoporosis |
| □ | □ | Jaw Pain | □ | □ | Abdominal Pain | □ | □ | Osteopenia |
| □ | □ | Joint Pain/Stiffness | □ | □ | Ulcer | □ | □ | Carotid Artery Disease/Condition |
| □ | □ | Arthritis | □ | □ | Hepatitis | **For Females Only** | | |
| □ | □ | Rheumatoid Arthritis | □ | □ | Liver/Gall Bladder Disorder | □ | □ | Birth Control Pills |
| □ | □ | Cancer | □ | □ | General Fatigue | □ | □ | Hormonal Replacement |
| □ | □ | Tumor | □ | □ | Muscular Incoordination | □ | □ | Pregnancy |
| □ | □ | Asthma | □ | □ | Visual Disturbances | **Possibility of pregnancy? Y N** | | |
| □ | □ | Chronic Sinusitis | □ | □ | Dizziness | | | |
| □ | □ | Other:_____ | | | | | | |

**18. List all prescription medications you are currently taking:**_____

**19. List all of the over-the-counter medications, vitamins or herbs you are currently taking:**

_____

**20. Any past trauma/injury to your spine?** □ No □ Yes, if yes describe _____

**21. Have you had significant past trauma?** □ No □ Yes, if yes describe_____

**22. Have you ever been hospitalized?** □ No □ Yes if yes, why _____

**23. List all surgical procedures you have had:**

_____

**24. Have you ever seen a Chiropractor before?** □ No □ Yes, **When was you last visit?** _____

**25. Have you tolerated hands on manipulation in the past?** □ Yes □ No □ Unsure

**26. Do you need an extremely light/gentle technique used? ?** □ Yes □ No □ Unsure

**27. Are you aware of or been diagnosed with any carotid artery disease/condition?** □ Yes □ No □ Unsure

**28. What activities do you do outside of work?** _____

**29. Anything else pertinent to your visit today?**_____

**Patient Signature**_____ **Date:**_____