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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

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Soc.Sec#_____

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:** _____

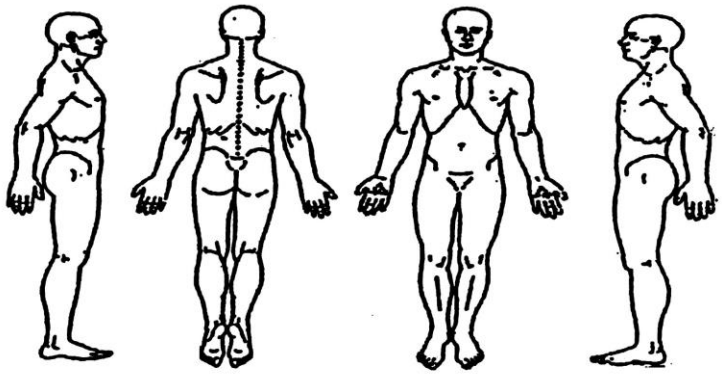
Insurance Information:

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

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

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

Patient Name_____

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 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	□	□	Osteoporosis
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Osteopenia
□	□	Joint Pain/Stiffness	□	□	Ulcer			
□	□	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 you are currently taking:

_____

20. List vitamins or herbs you are currently taking: _____

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

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

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

24. List all surgical procedures you have had:

_____

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

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

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

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

29. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____