

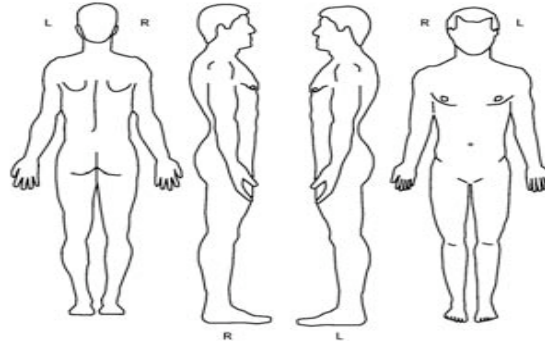


PATIENT INTAKE FORM

Patient Name: _____

Date: _____

Please indicate on the drawings below where you have symptoms in order of severity of pain



Primary Complaint: (List ONE Complaint at a time. For complaints please see next sheet.)

Right/Left Headaches Right/ Left Elbow/Wrist Right/Left Upper Back Right/Left Jaw Right/Left Neck
 Right/Left Leg Right/Left Mid Back Right/Left Hip Right/Left Shoulder Right/Left Knee Right/Left Low
 Back Right/Left Foot/Ankle Right/Left Arm/Hand Other No pain

1. How would you describe the type of pain?

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

2. 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)

3. How long have you had this problem? _____ days _____ weeks _____ months _____ years

4. How do you think it began?

unknown poor posture auto accident work injury from a fall yardwork/housework leisure
 activities sports injury

5. What aggravates your primary problem?

Bending Sleeping While at work Driving a car Stair Climbing Work at computer Standing up Working out
 Golfing Standing for long Painting Stress Playing tennis Traveling Running Walking Sitting Weather
 changes None Other _____

6. What alleviates your primary problem?

Adjustments Massage Tylenol Analgesic cream Muscle relaxors Walking Bending forward NSAIDS
 Warm baths Exercising Pilates Wearing orthotics Heat prescription pain meds Yoga Ice Resting
 Other Listen to relaxing music Standing Lying face down Stretching Swimming Lying on side/back

Secondary Complaint:

Right/Left Headaches Right/ Left Shoulder Right/Left Low Back Right/Left Mid Back Right/Left Upper
 Back Right/Left Knee Right/Left Leg Right/Left Hip Right/Left Neck Right/Left Elbow/Wrist Right/Left
 Jaw Right/Left Foot/Ankle Right/Left Arm/Hand Other

1. How would you describe the type of pain?

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

2. 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)

3. How long have you had this problem? ___ days ___ weeks ___ months ___ years

4. How do you think it began?

unknown poor posture auto accident work injury from a fall yardwork/housework leisure activities sports injury

5. What aggravates your primary problem?

Bending Sleeping While at work Driving a car Stair Climbing
 Work at computer Standing up Working out Golfing Standing for long
 Painting Stress Playing tennis Traveling Running
 Walking Sitting Weather changes None Other _____

6. What alleviates your secondary problem?

Adjustments Massage Tylenol Analgesic cream
 Muscle relaxors Walking Bending forward NSAIDS
 Warm baths Exercising Pilates Wearing orthotics
 Heat prescription pain meds Yoga Ice
 Resting Other Listen to relaxing music Standing
 Lying face down Stretching Swimming Lying on side/back

1. How are your symptoms changing with time?

Getting Worse Not changing Getting Better

2. How often do you experience your symptoms?

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

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

4. How much has the problem interfered with your work?

Not at all A little bit Moderately Quite a bit Extremely

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

Not at all A little bit Moderately Quite a bit Extremely

6. Who else have you seen for your problem?

Chiropractor Neurologist Primary Care Physician ER physician Orthopedist
 Other: _____ Massage Therapist Physical Therapist No one

7. Please provide the name and location of your Primary Care Physician _____

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

9. What concerns you the most about your problem?

it could be serious it isn't going away affecting leisure time affecting work
 could be getting worse affecting golf affecting sleep affecting mental outlook
 affecting relationships other

1. What is your: Height _____ **Weight** _____ **DOB** _____

2. What is your Occupation _____

3. How would you rate your Health? Excellent Very Good Good Fair Poor

Strenuous Moderate Light None

5. Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis Diabetes Lupus None Heart Problems Cancer ALS
 Other

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

7. List all prescription or over-the-counter medications you are currently taking:

8. List all of the supplements you are currently taking:

9. List all surgical procedures you have had:

10. What activities do you do at work? Sits Stands Computer Phone Drives Other

Most of the day Most of the day Most the day Most of the day Most of the day _____ Half of the day Half of the day Half the day Half of the day Half of the day Little of the day Little of the day Little of the day Little of the day

11. What sports or leisure activities do you do outside of work? _____

12. Have you ever seen a chiropractor in the past? No Yes If yes, how long ago and what were the results. _____

13. Have you ever been hospitalized? No Yes If yes, explain _____

14. Have you had significant past trauma? No Yes If yes, explain _____

15. Anything else pertinent to your visit today? _____