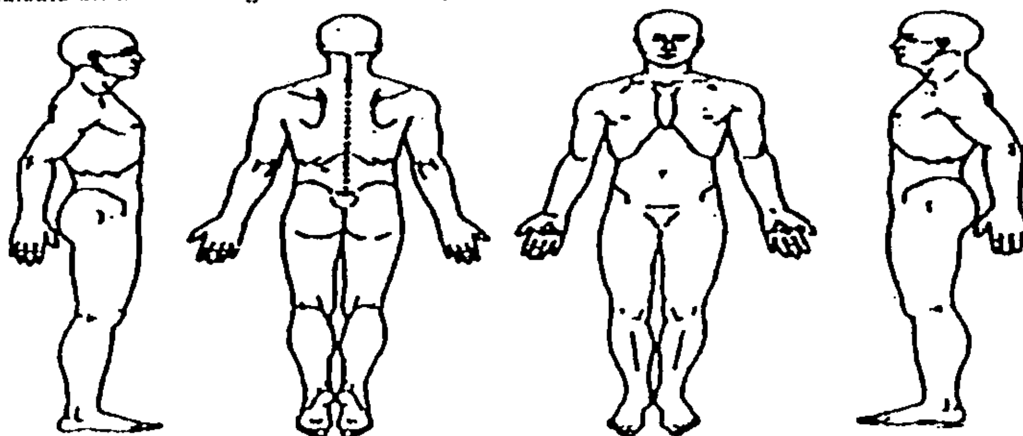
PATIENT INTAKE FORM

Patient Name: ______________________________ Date: ______________

1. **Is today's problem caused by:** ▢ Auto Accident ▢ Workman's Compensation

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



3. **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)

4. **How would you describe the type of pain?**
   - ▢ Sharp
   - ▢ Dull
   - ▢ Diffuse
   - ▢ Achy
   - ▢ Burning
   - ▢ Shooting
   - ▢ Stiff
   - ▢ Numb
   - ▢ Tingly
   - ▢ Sharp with motion
   - ▢ Shooting with motion
   - ▢ Stabbing with motion
   - ▢ Electric like with motion
   - ▢ Other: ______________

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

9. **Who else have you seen for your problem?**
   - ▢ Chiropractor
   - ▢ ER physician
   - ▢ Massage Therapist
   - ▢ Neurologist
   - ▢ Orthopedist
   - ▢ Physical Therapist
   - ▢ Primary Care Physician
   - ▢ Other: ____________
   - ▢ 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?**
▢ Yes ▢ Yes, at times ▢ No

13. **What aggravates your problem?**

____

14. **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?
□ Stenuous □ 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
□	□ 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:____________				

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 surgical procedures you have had:

____

23. 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

24. What activities do you do outside of work?

____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why ____________________

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?____________________

Patient Signature____________________ Date:____________