Date_____

National University of Health Sciences

Clinic Off-Site Event Intake Form

Please Print
First and
Last Name_____ Telephone ( )_____ Date of Birth_____ Age_____

Address_____ City_____ State_____ Zip Code_____

Problem: Related to running? **Y N** Describe:_____

Recent Trauma or injuty? **Y N** Date of Injury:_____ Describe:_____

How long has this been painful?_____

Do you know why this started?_____

Circle if it is getting: **Better Worse Staying Constant**

Painful when running? **Y N** Painful when resting? **Y N** Other?_____

What makes you feel better?_____

What makes you feel worse?_____

Does the pain travel to another area? Describe:_____

Currently being treated by an M.D. or nurse? **Y N** If yes, what for?_____

_____

Currently being treated by a chiropractor? **Y N** If yes, what for?_____

_____

Had a previous injury like this one? **Y N** If yes, what was it?_____

_____

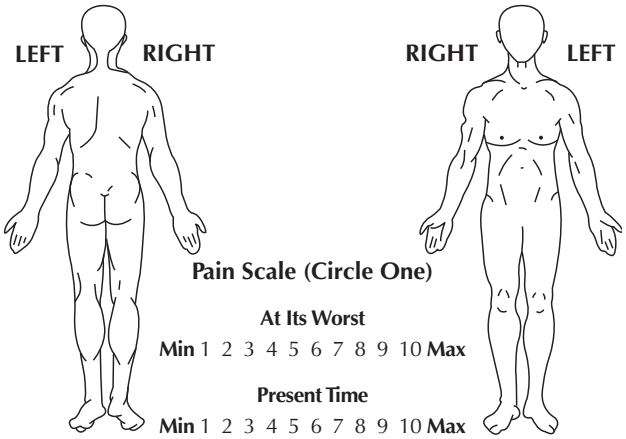
Are you on any medications? **Y N** If yes, what kind?_____

_____

Do you wear orthotics? **Y N** If yes, date of last pair obtained:_____

Please mark on the figures where you are experiencing pain

Quality of Pain: **Dull Achy Sharp Stabbing Tingling Numb Throbbing**



Pain Scale (Circle One)

At Its Worst
Min 1 2 3 4 5 6 7 8 9 10 **Max**

Present Time
Min 1 2 3 4 5 6 7 8 9 10 **Max**

Please circle where appropriate if you currently have or previously had any of the following: **Heart Disease Atherosclerosis Dizziness Ringing in the Ear Stroke Blackouts Clots in Legs Infection Headaches High Blood Pressure Cancer TB Diabetes Arthritis Surgery Car Accident Allergies Weight Change > 10 lbs Spinal Disorders**_____

Other Complaints:_____

I understand that the examination and treatment I am to receive is not intended to be a comprehensive health evaluation. Rather, it is of a limited nature, intended to focus strictly on the current symptoms I am experiencing, for the purpose of alleviating these symptoms. If these symptoms do not resolve, it is recommended that I seek prompt attention from a qualified health care professional. I have read and understand all of the information above, and I answered each question to the best of my knowledge.

Signature:_____ **Date:**_____

PATIENTS DO NOT WRITE BELOW THIS LINE

_____

_____

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