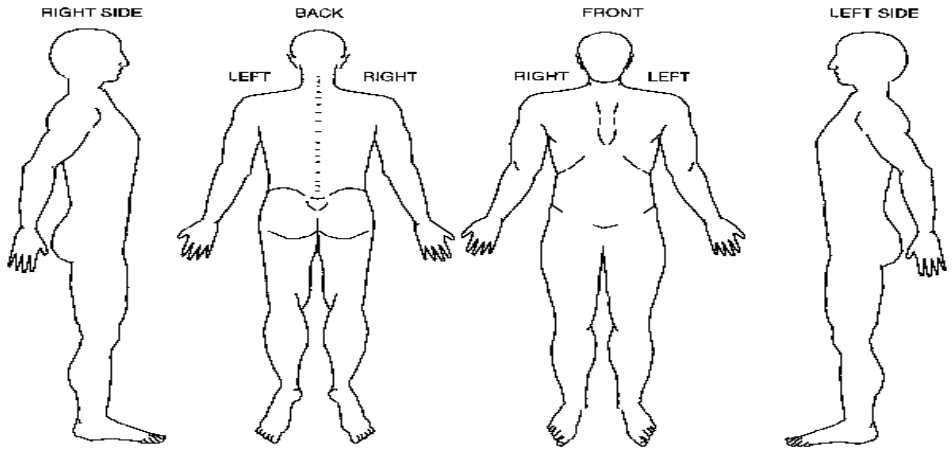
Patient Intake Form

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 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 □ Numb
   □ Dull □ Tingly
   □ Diffuse □ Sharp with Motion
   □ Achy □ Shooting with Motion
   □ Burning □ Stabbing with Motion
   □ Shooting □ Electric like with Motion
   □ Stiff □ Other: _____
5. **How are your symptoms changing with time?**
   □ Getting Worse □ Staying the Same □ Getting better
6. **Using a scale of 0-10 (0 being the worst), how would you rate your problem?**
   CIRCLE ONE: 0 1 2 3 4 5 6 7 8 9 10
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 □ Massage Therapist □ Orthopedist □ Primary Care
   □ ER Physician □ Neurologist □ Physical Therapist □ No one
   □ Other: _____
10. **How long have you had this problem? _____**
11. **How do you think your problem began? _____**
12. **Do you consider your 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 _____ DOB _____

Occupation _____

16. How would you rate your overall health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any family members with the following:

□ Rheumatoid Arthritis □ Lupus □ Cancer

□ Heart Problems □ ALS □ Diabetes

19. For each condition 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	□	□ Tabacco Use
□	□ Lower back Pain	□	□ Angina	□	□ Drug/ Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/ Upper arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systematic 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	**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 taking: _____

22. List all medical procedures you have had: _____

23. What activities do you do at work?

SIT:	□ All day	□ Most of the day	□ A little of the day
STAND:	□ All day	□ Most of the day	□ A little of the day
COMPUTER WORK:	□ All day	□ Most of the day	□ A little of the day
ON THE PHONE:	□ All day	□ Most of the day	□ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? □ Yes, why _____

□ No

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

27. Anything else pertinent to your visit today?

Patient Signature _____ Date _____