CONFIDENTIAL PATIENT INTAKE FORM

https://pillarchiropractic.com

NAME: _____AGE:_____DOB:_____SS#_____

HOME ADDRESS: _____CITY:_____ST:_____ZIP_____

EMPLOYER: _____OCCUPATION:_____E-MAIL_____

HOME TEL: _____PAGER/CELL: _____WORK TEL: _____FAX:_____

PREFERRED METHOD OF CONTACT: ☐HOME TEL ☐CELL TEL ☐WORK TEL ☐EMAIL

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ TEL:_____

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐SIGNIFICANT OTHER ☐DIVORCED ☐WIDOWED # CHILDREN_____

RACE: ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐BLACK OR AFRICAN AMERICAN
☐NATIVE OR OTHER PACIFIC ISLANDER ☐WHITE ☐PATIENT DECLINED TO PROVIDE

ETHNICITY: ☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATINO ☐PATIENT DECLINED TO PROVIDE

PRIMARY CARE PHYSICIAN: _____ PHYSICIAN PHONE: _____

REFERRED BY: DR._____ PATIENT: _____ OTHER_____

YOU ARE *CURRENTLY* EXPERIENCING: ☐BACK PAIN ☐NECK PAIN ☐HEADACHE ☐OTHER_____

DESCRIBE☐:_____

THIS HAPPENED *WHEN?* _____ *WHERE?* ☐HOME ☐WORK ☐CAR WRECK ☐OTHER_____

THIS HAPPENED *HOW?* _____

HAVE YOU HAD THIS OR SIMILAR HAPPEN BEFORE? _____

WHAT MAKES THE PROBLEM BETTER? _____

WHAT MAKE THE PROBLEM WORSE? ☐SITTING ☐STANDING ☐LYING ☐MOVEMENT ☐REST
☐USE ☐WALKING ☐RUNNING ☐WORKING ☐ACTIVITY
☐BENDING ☐LIFTING ☐TWISTING ☐OTHER_____

DESCRIBE THE PAIN OR SENSATION: ☐ACHY ☐BURNING ☐DULL ☐NUMB ☐SHARP
☐SHOOTING ☐SORE ☐STABBING ☐STIFF ☐TINGLING

DOES THE PAIN RADIATE TO ANOTHER AREA OF THE BODY? ☐NO ☐YES - *WHERE*? _____

HOW FREQUENT IS THE PROBLEM? ☐CONSTANT ☐FREQUENT ☐INTERMITTENT ☐OCCASIONAL
☐EVENING ONLY ☐MORNING ONLY ☐WORSE IN THE: ☐AM or ☐PM

WHAT % OF THE DAY DO YOU EXPERIENCE THIS PROBLEM? ☐0-25% ☐26-50% ☐51-75% ☐76-100%

OTHER DR.S SEEN FOR THIS CONDITION: ☐ NO ☐YES:_____WHEN? _____

PAST CHIROPRACTIC CARE: ☐NO ☐YES DRS NAME: _____WHEN? _____

PATIENT SIGNATURE: _____ DATE: _____
GUARDIAN SIGNATURE: _____ DATE: _____

REVIEW OF SYSTEMS AND HISTORY

Check or circle the appropriate response, please leave blank if it does not apply.

Past Medical and/or Family History

P = patient M = mother
F = father S = sibling

☐ Heart Disease	P M F S
☐ Asthma	P M F S
☐ Cancer	P M F S
☐ Arthritis	P M F S
☐ Headaches	P M F S
☐ Diabetes	P M F S
☐ MVP	P M F S
☐ Emphysema	P M F S
☐ Anemia	P M F S
☐ Fibromyalgia	P M F S
☐ Hernia	P M F S
☐ High BP	P M F S
☐ Low BP	P M F S
☐ Alzheimers	P M F S
☐ Alcoholism	P M F S
☐ Colitis	P M F S
☐ Epilepsy	P M F S
☐ Goiter	P M F S
☐ Gout	P M F S
☐ High Cholesterol	P M F S
☐ Kidney Disease	P M F S
☐ Leukemia	P M F S
☐ Lupus	P M F S
☐ Mental Condition	P M F S
☐ Obesity	P M F S
☐ Rheumatoid Arth.	P M F S
☐ Ulcers	P M F S
☐ Injuries	P M F S
☐ Trauma auto/etc.	P M F S
☐ Other _____	P M F S

Surgical History

☐ Appendectomy	☐ Hemorrhoid
☐ Gall Bladder	☐ Tonsillectomy
☐ Thyroidectomy	☐ Kidney Stone
☐ Bladder	☐ Endoscopy
☐ Angioplasty	☐ Heart Bypass
☐ Back Surgery	☐Neck Surgery

☐ Arthroscopic_____
☐ Joint Replacement_____

☐ Mastectomy	☐ Breast Implants
☐ Tubaligation	☐ C-Section
☐ Endometriosis	☐ Hysterectomy

☐ Other_____
☐ Other_____

Social History

Caffeine: ☐ No ☐ Light ☐ Heavy
Tobacco: ☐ No ☐ Yes
Packs Per day_____
Alcohol: ☐ No ☐ Yes
_____per day/week

Work History

☐ No work ☐ Part time
☐ Full Time ☐ School
☐ Retired ☐ Disability

Exercise

☐ Frequently
☐ Occasionally
☐ Rarely/Never

Females

Pregnant: ☐Yes ☐No ☐I Don=t Know
☐ Last Menstrual Cycle_____

Males

☐ Prostate problems

Present Medication

☐None
☐List_____
_____
_____
_____
_____
_____

Allergies

☐ Penicillin ☐ Codeine
☐ Sulfa ☐ Aspirin
☐ Other _____
☐ Other _____

Review Of Systems

Please circle if you have had any problems in any of the following:
(P=Past, 1=Mild, 2=Moderate, 3=Severe)

General Health

P 1 2 3 Fatigue/Tiredness
P 1 2 3 Fever/Night Sweats
P 1 2 3 Trouble Sleeping
P 1 2 3 Skin Irritation/Rash
P 1 2 3 Bleeding Disorder
P 1 2 3 Depression
P 1 2 3 Anxiety/Tension/Stress

EENT

P 1 2 3 Vision/Eye
P 1 2 3 Hearing/Ear
P 1 2 3 Throat/Swallowing
P 1 2 3 Nasal/Sinus
P 1 2 3 Headaches/Face Pain

Cardiopulmonary

P 1 2 3 Breathing
P 1 2 3 Swelling/Edema
P 1 2 3 Chest Pain

GI

P 1 2 3 Stomach/Abdominal
P 1 2 3 Diarrhea/Constipation
P 1 2 3 Vomiting

GU

P 1 2 3 Urinary Frequency/Urgency
P 1 2 3 Urinary/Burning/Discoloration
P 1 2 3 Sexual/Reproductive

Skeletal

P 1 2 3 Morning Stiffness
P 1 2 3 Night Pain
P 1 2 3 Neck Pain
P 1 2 3 Back Pain
P 1 2 3 Joint Pain_____
☐ Fracture_____

NeuroMuscular

P 1 2 3 Muscle Pain
P 1 2 3 Weakness
P 1 2 3 Numbness/Tingling
P 1 2 3 Tremors/Shakes
P 1 2 3 Loss of Consciousness
P 1 2 3 Passing out

Patient Signature_____Date:_____
Reviewer_____Date:_____

PAIN DRAWING

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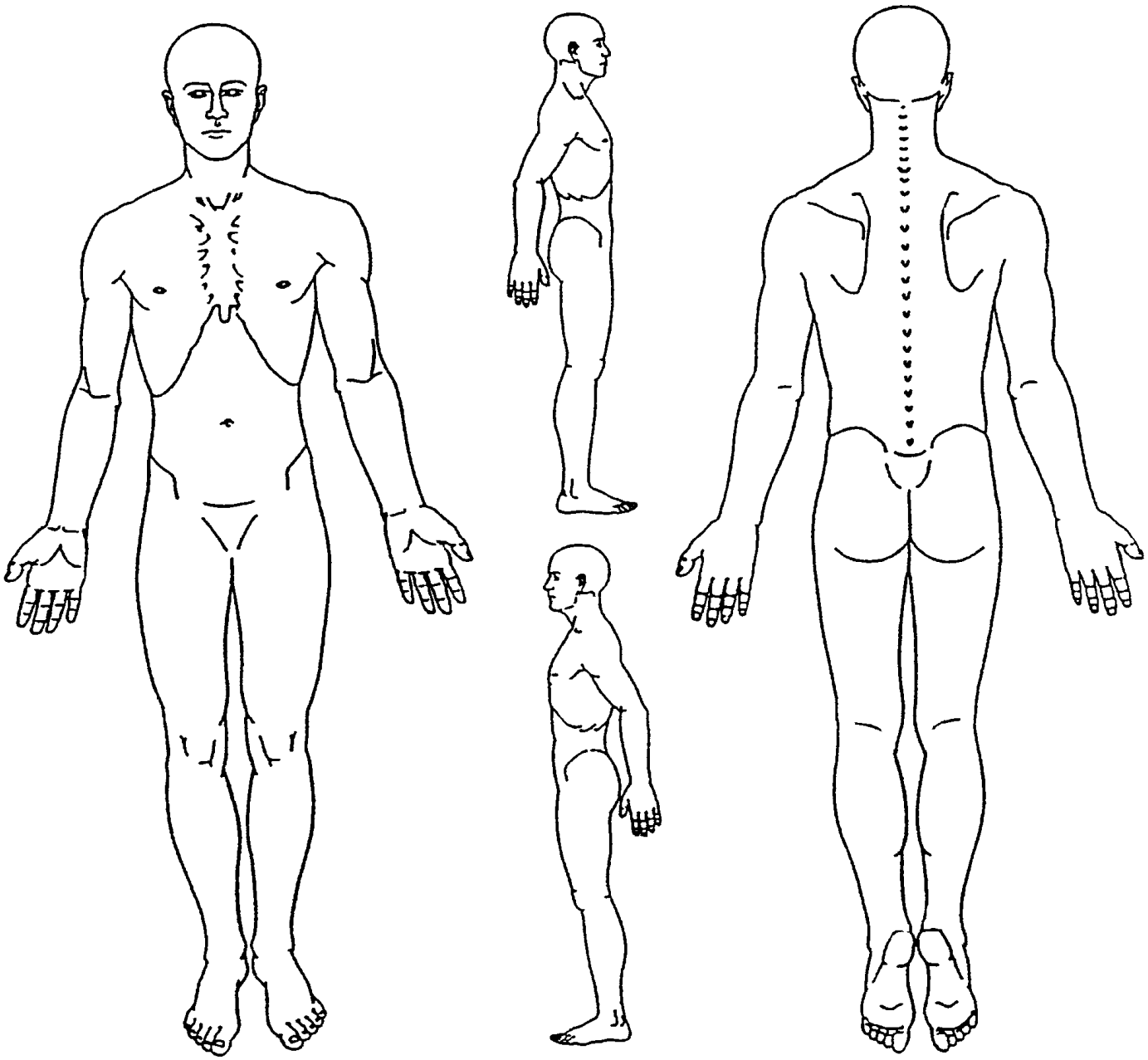
On the diagrams below please mark where you are experiencing your symptoms.

X = PAIN / DISCOMFORT
O = NUMBNESS / TINGLING



PAIN SEVERITY SCALE: Rate the severity of your pain by marking all that apply:
N for neck pain, **MB for mid back pain**, **LB for low back pain** and/or **X for other pain** in box on the following scale:

0	1	2	3	4	5	6	7	8	9	10

No Pain **Excruciating Pain**

Signature: _____ Date: _____ rev11.15.2023