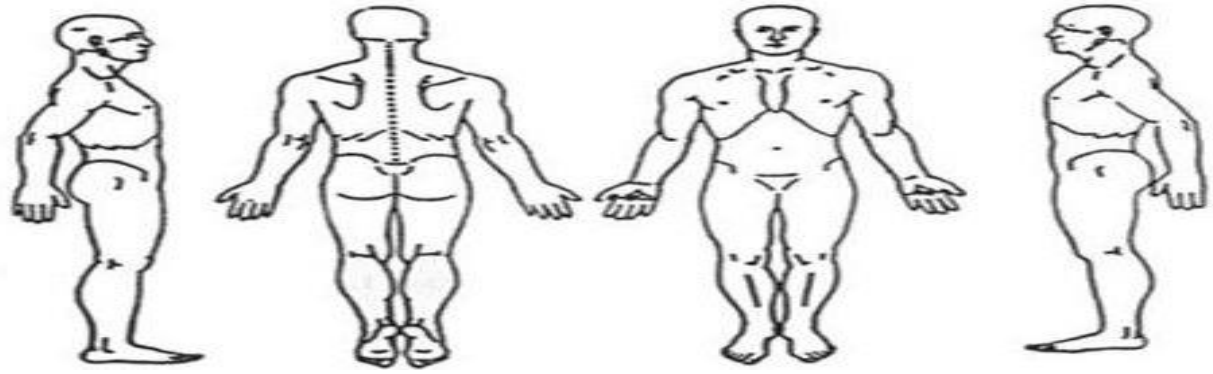
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem cause 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)
   - □ Frequently (51 – 75% of the time)
   - □ Occasionally (26 – 50% 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? (Please circle)
   0 1 2 3 3 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
   - □ ER Physician
   - □ Physical Therapist
   - □ Neurologist
   - □ Orthopedist
   - □ No One
   - □ Primary Care Physician
   - □ Massage Therapist
   - □ Other: _____

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 _____Ft _____In Weight _____ Blood Pressure _____/_____

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 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
□	□ Headache	□	□ 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 Dependence
□	□ 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	□	□ Hepatitis
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Dizziness
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Cancer
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Tumor
□	□ Arthritis	□	□ Liver/Gall Bladder Disorder	**FOR FEMALES ONLY**	
□	□ Rheumatoid Arthritis	□	□ Chronic Sinusitis	□	□ Birth Control Pills
□	□ Muscular Incoordination	□	□ General Fatigue	□	□ Hormonal Replacement
□	□ Visual Disturbances	□	□ Asthma	□	□ Pregnancy
□	□ Other _____				

20. List all Prescription medications you are currently taking:

_____

21. Are you allergic to any prescription drugs? □ No □ Yes If yes, which ones?

_____

22. List all of the medications/supplements/vitamins you are currently taking

_____

23. List all surgical procedures you have had:

_____

24. Have you ever been hospitalized? □ No □ Yes If yes, why

_____

25. Have you had significant trauma? □ No □ Yes

_____

26. What activities do you do at work?

□ Sit:	□ Most of the day	□ Half of the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half of the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half of the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half of the day	□ A little of the day

27. Anything else pertinent to your visit today?

_____

Patient Signature _____ Date _____