## **PATIENT INTAKE FORM**

Patient Name: Date:
<b>1. Is today's problem caused by:</b> □ 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)  Intermittently (1-25% of the time)
4. How would you describe the type of pain?  Sharp Numb Dull Tingly Sharp with motion Shooting Shooting with motion Shooting Electric like with motion Stiff Other:
<b>5. How are your symptoms changing with time?</b> □ 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 □ Neurologist □ Primary Care Physician  □ ER physician □ Orthopedist □ Other:  □ Massage Therapist □ Physical Therapist □ 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 Age

Occ	cupation				
<b>16. How would you </b> □ Excellent □ Ve	rate your overall Hery Good 🗈 Goo		□ Poor		
<b>17. What type of exe</b> □ Stenuous □ I		_ight □ None	е		
18. Indicate if you ha	ave any immediate	family members	with any of t	he following:	
□ Rheumatoid Arthriti □ Heart Problems	S	□ Diabetes □ Cancer		□ Lupus □ ALS	
	aanditiana liatad b		ale in the line		hava had tha
<ol><li>For each of the condition in the past column.</li></ol>					
Past Present	Past	Present	Pa	ast Present	
□ □ Headaches		□ High Blood Properties of the properties of	ressure 🗆		
□ Neck Pain		□ Heart Attack			
□ □ Upper Back		<ul> <li>Chest Pains</li> </ul>		- 1	
□ Mid Back Pa		□ Stroke			Tobacco Use
□ Low Back Pa	-	□ Angina		•	I Dependance
□ □ Shoulder Pa		□ Kidney Stone		0	
□ □ Elbow/Upper	r Arm Pain 🛚	□ Kidney Disord			
□ Wrist Pain		□ Bladder Infec		,	Lupus
□ Hand Pain		□ Painful Urinat		□ Epilepsy	
□ Hip Pain		□ Loss of Bladd		□ Dermatitis/Ed	
□ Upper Leg P		□ Prostate Prob		_	
□ Knee Pain	Dain	□ Abnormal We			
□ Ankle/Foot F		□ Loss of Appet		For Females O	•
□ Jaw Pain		□ Abdominal Pa			
□ Joint Pain/St		□ Ulcer			Replacement
□ Arthritis	A	□ Hepatitis		- 5	у
□ Rheumatoid		□ Liver/Gall Bla		ſ	
□ □ Cancer		<ul> <li>□ General Fatig</li> <li>□ Muscular Income</li> </ul>			
□ □ Tumor □ □ Asthma		□ Visual Disturb			
01	⊔sitis □	□ Visual Distuit	Jances		
□ □ Chronic Sinu □ □ Other:	131113	□ DIZZII IC33			
20. List all prescripti	ion medications yo	ou are currently to	aking:		
21. List all of the ove	er-the-counter med	lications you are	currently tak	rina	
er. Eist an or the ove	or the counter mee	modificities you are	- Currently tar	y.	
22. List all surgical p	orocedures you ha	ve had:			
23. What activities d	•				
⊐ Sit:	□ Most of the		☐ Half the day		le of the day
⊐ Stand:	□ Most of the		∃ Half the day		le of the day
□ Computer work:	□ Most of the		∃ Half the day		le of the day
□ On the phone:	□ Most of the	day 🗆	□ Half of the d	lay □ A litt	le of the day
24. What activities d	o you do outside d	of work?			
25. Have you ever be f yes, why		□ No □ Yes	s		
26. Have you had siç	-		Yes		
27. Anything else pe	ertinent to your vis	it today?			
Patient Signature			Date:		