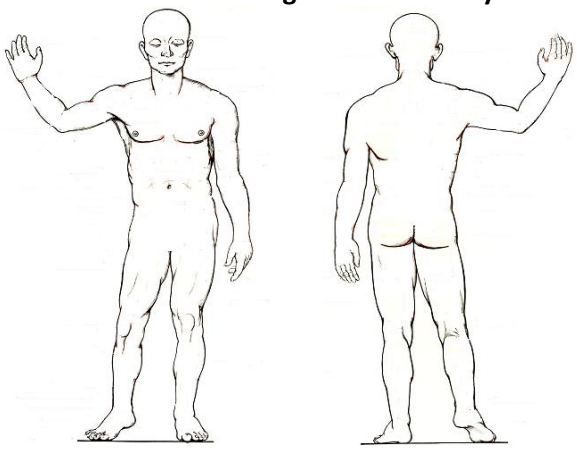
Patient Intake Form

Name:_____ Date:_____

1. **Is today's problem cased by:** ☐ Auto accident☐ Worker's Comp ☐ Other_____
2. **Indicate on the drawings below where you have pains/symptoms**



3. **How often do you experience your symptoms?**
   ☐Constantly (76-100%) ☐Frequently (51-75%) ☐Occasionally (26-50%) ☐Intermittently (1-25%)
4. **How would you describe the type of pain?**
   ☐Sharp ☐Dull ☐Diffuse ☐Achy ☐Burning ☐Shooting ☐Stiff ☐Numb ☐Tingly
   ☐Sharp with motion ☐Shooting w/ motion ☐Stabbing with motion ☐Electric w/ motion
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? (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 bit ☐Extremely
8. **How much has the problem interfered with your social activities?**
   ☐Not at all ☐A little bit ☐Moderately ☐Quite bit ☐Extremely
9. **Who else have you seen for your problem?**
   ☐Chiropractor ☐ER Physician ☐Massage Therapy ☐Neurologist ☐Orthopedist ☐Physical Therapist ☐Primary Care Physician ☐Other_____ ☐No One
10. **How long have you had this problem?_____**
11. **How do you think your problem began?_____**
12. **Do you consider this problem 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?_____**
16. **How would you rate your overall Health?** ☐Excellent ☐Very Good ☐Fair ☐Poor
17. **What type of exercise do you do?** ☐Strenuous ☐Moderate ☐Light ☐None

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

☐Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐Lupus ☐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 have a condition listed below, place in the "present" column.**

Past	Present	Past	Present	Past	Present
☐	☐Headaches	☐	☐High Blood Pressure	☐	☐Diabetes
☐	☐Upper back pain	☐	☐Heart Attack	☐	☐Excessive Thirst
☐	☐Mid back pain	☐	☐Chest Pains	☐	☐Frequent Urination
☐	☐Low back pain	☐	☐Stroke	☐	☐Smoking/Tobacco Use
☐	☐Shoulder pain	☐	☐Angina	☐	☐Drug/Alcohol Depend
☐	☐Elbow/Upper Arm	☐	☐Kidney Stones	☐	☐Allergies
☐	☐Wrist	☐	☐Kidney Disorders	☐	☐Depression
☐	☐Hand	☐	☐Bladder Infection	☐	☐Systemic Lupus
☐	☐Hip pain	☐	☐Painful Urination	☐	☐Epilepsy
☐	☐Upper leg pain	☐	☐Loss of Bladder Control	☐	☐Dermatitis/Eczema/Rash
☐	☐Knee Pain	☐	☐Prostate Problems	☐	☐HIV/AIDS
☐	☐Ankle/Foot pain	☐	☐Abnormal Weight Gain/Loss	**For females only**	
☐	☐Jaw Pain	☐	☐Loss of Appetite	☐	☐Birth Control Pills
☐	☐Joint Pain/Stiffness	☐	☐Abnormal Pain	☐	☐Hormonal Replacement
☐	☐Arthritis	☐	☐Ulcer	☐	☐Pregnancy
☐	☐Rheumatoid Arthritis	☐	☐Hepatitis		
☐	☐Cancer	☐	☐Liver/Gall Bladder Disorder		
☐	☐Tumor	☐	☐General Fatigue		
☐	☐Asthma	☐	☐Muscular In coordination		
☐	☐Chronis Sinusitis	☐	☐Visual Disturbances		
☐	☐Other:_____	☐	☐Dizziness		

20. **List all prescription medications you are currently taking:**

_____

21. **List all of the over-the-counter medications you are currently taking:**

_____

22. **List all surgical procedures you have had:**

_____

23. **What activities do you do at work?**

☐**Sit:**	☐Most of the day	☐Half the day	☐A little of the day
☐**Stand:**	☐Most of the day	☐Half the day	☐A little of the day
☐**Computer work:**	☐Most of the say	☐Half the day	☐A little of the day
☐**On the phone:**	☐Most of the day	☐Half the day	☐A little of the day

24. **What activities do you do outside of work?_____**
25. **Have you been hospitalized? ☐No ☐Yes** If yes , why?_____
26. **Have you had significant past trauma? ☐Yes ☐No**
27. **Anything else pertinent to your visit today?_____**

Patient Signature:_____ Date:_____

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