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					
A A					
3. How often do you experience ye					
 □ Constantly (76-100% of the □ Frequently (51-75% of the □ Frequently (51-75%) 		 Occasionally (26-50% of the time) Intermittently (1-25% of the time) 			
4. How would you describe the typ					
□ Dull □ Diffuse □ Sharp v □ Achy □ Burning □ Shooting	 Numb Tingly with motion Shooting with r Stabbing with r Electric like wit Other: 	motion			
5. How are your symptoms chang □ Getting Worse □ Staying	ing with time? g the Same	Getting Better			
6. Using a scale from 0-10 (10 bein 0 1 2 3 4 5 6 7		ow would you rate your problem? ase circle)			
7. How much has the problem interaction of the p	erfered with you Moderately	r work? □ Quite a bit □ Extremely			
8. How much has the problem interaction of the second seco	erfered with you	r social activities? Quite a bit □ Extremely			
9. Who else have you seen for youChiropractorNeuroloER physicianOrthopMassage TherapistPhysica	ogist	□ Primary Care Physician □ Other: □ No one			
10. How long have you had this pr	roblem?				
11. How do you think your problem	m began?				
12. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No					
13. What aggravates your problen	n?				
14. What concerns you the most about your problem; what does it prevent you from doing?					
15. What is your: Height Occupation	Weight	Age	-		
16. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor					
17. What type of exercise do you of stenuous □ Moderate		□ 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
	Headaches		High Blood Pressure		Diabetes
	Neck Pain		Heart Attack		Excessive Thirst
	Upper Back Pain		Chest Pains		Frequent Urination
	Image: Mid Back Pain		Stroke		Smoking/Tobacco Use
	Low Back Pain		Angina		Drug/Alcohol Dependance
	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 Contro		Dermatitis/Eczema/Rash
	Upper Leg Pain		Prostate Problems		□ HIV/AIDS
	Knee Pain		Abnormal Weight Gain/	Loss	
	Ankle/Foot Pain		Loss of Appetite	F	or Females Only
	Jaw Pain		Abdominal Pain		Birth Control Pills
	Joint Pain/Stiffness		Ulcer		Hormonal Replacement
	Arthritis		Hepatitis		Pregnancy
	Rheumatoid Arthritis		Liver/Gall Bladder Diso	rder	
	Cancer		General Fatigue		
	🗆 Tumor		Muscular Incoordination	า	
	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 currently taking:

22. List all surgical procedures you have had:

 23. What activities do Sit: Stand: Computer work: On the phone: 	 Most of the day Most of the day Most of the day 	 □ Half the day □ Half the day □ Half the day □ Half of the day 	 □ A little of the day 					
24. What activities do you do outside of work?								
25. Have you ever been if yes, why	en hospitalized? □ No	□ Yes						
26. Have you had sigr	nificant past trauma? 🛛 🗆 No	o 🗆 Yes						
27. Anything else per	inent to your visit today?							
Patient Signature		Date:						