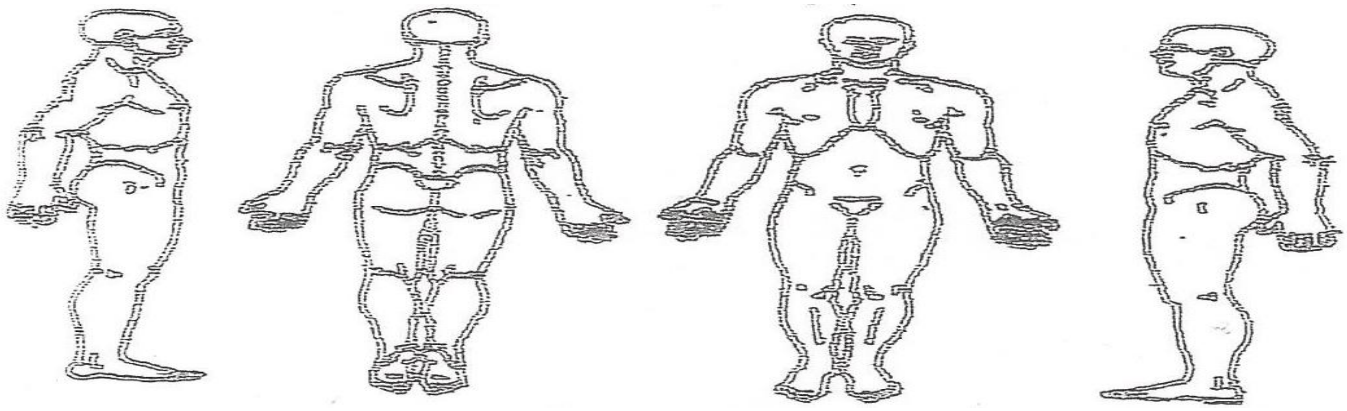
PATIENT INTAKE FORM

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:



3. How often do you experience symptoms?

○ Constantly (76-100% of the time) ○ Occasionally (26-50% 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 __ Burning __ Tingly __ Electric w/ motion
__ Dull __ Shooting __ Sharp w/ motion __ Other
__ Diffuse __ Stiff __ Shooting w/ motion _____
__ Achy __ Numb __ Stabbing w/ motion

5. How are your symptoms changing w/ time?

○ Getting Worse ○ Staying the Same ○ Getting Better

6. Using a scale from 1 - 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 this problem?

__ Chiropractor __ Neurologist __ Primary Care Physician
__ ER Physician __ Orthopedist __ Other _____
__ Massage Therapist __ Physical Therapist

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 _____ Date of Birth _____

16. What is your occupation? _____

17. How would you rate your overall health?

__ Excellent __ Very Good __ Good __ Fair __ Poor

18. What type of exercise do you do?

__ Strenuous __ Moderate __ Light __ None

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

__ Rheumatoid Arthritis __ Diabetes __ Lupus __ Heart Problems

__ Cancer __ ALS

20. 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	
__	__	Headaches	__	__	Asthma
__	__	Neck Pain	__	__	Chronic Sinusitis
__	__	Upper Back Pain	__	__	High Blood Pressure
__	__	Mid Back Pain	__	__	Heart Attack
__	__	Lower Back Pain	__	__	Chest Pains
__	__	Shoulder Pain	__	__	Stroke
__	__	Elbow/Upper Arm Pain	__	__	Angina
__	__	Wrist Pain	__	__	Kidney Stones
__	__	Hand Pain	__	__	Kidney Disorders
__	__	Hip Pain	__	__	Bladder Infection
__	__	Upper Leg Pain	__	__	Painful Urination
__	__	Knee Pain	__	__	Loss of Bladder Control
__	__	Ankle/Foot Pain	__	__	Prostate Problems
__	__	Jaw Pain	__	__	Abnormal Weight Gain/Loss
__	__	Joint Pain/Stiffness	__	__	Loss of Appetite
__	__	Arthritis	__	__	Abdominal Pain
__	__	Rheumatoid Arthritis	__	__	Ulcer
__	__	Cancer	__	__	Hepatitis
__	__	Tumor	__	__	Liver/Gall Bladder Disorder
__	__	General Fatigue	__	__	Diabetes
__	__	Muscular Incoordination	__	__	Excessive Thirst
__	__	Visual Disturbances	__	__	Frequent Urination
__	__	Dizziness	__	__	Smoking/Tobacco Use
__	__	Allergies	__	__	Drug/Alcohol Dependence
__	__	Depression	__	__	Systemic Lupus
__	__	Epilepsy	__	__	HIV/Aids
__	__	Dermatitis/Eczema Rash	__	__	Birth Control Pills
__	__	Hormonal Replacement	__	__	Pregnancy

21. List all prescription medications you are currently taking: _____

_____

22. List all OTC medications you are currently taking:

23. List all surgical procedures you have had:

24. What activities do you do at work?

__ Sit	__	Most of the day	__ Half of day	__ Little of day
__ Stand	__	Most of the day	__ Half of day	__ Little of day
__ Computer work	__	Most of the day	__ Half of day	__ Little of day
__ On the phone	__	Most of the day	__ Half of day	__ Little of day

25. What activities do you do outside of work?

26. Have you been hospitalized? __ Yes __ No If Yes, Why?

27. Have you had significant past trauma?

Patient Signature: Date: