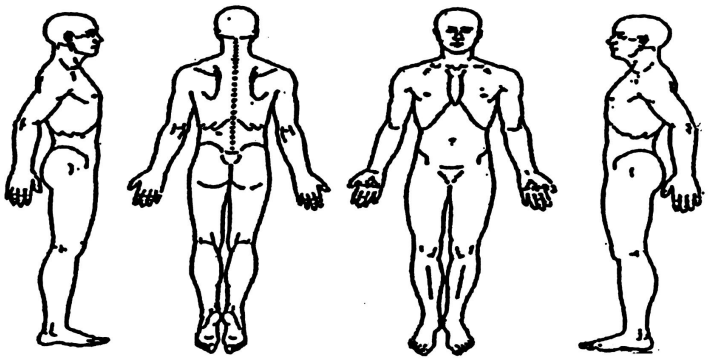
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Reasons for seeking chiropractic care:_____
_____
_____
_____

Indicate on the drawings below where you have pain/symptoms _____



3. How often do you experience your 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? (Check all that apply.)

□ Sharp	□ Shooting	□ Shooting with motion
□ Dull	□ Stiff	□ Stabbing with motion
□ Diffuse	□ Numb	□ Electric like with motion
□ Achy	□ Tingly	□ Other:_____
□ Burning	□ Sharp with 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?

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 relieves your problem?

_____

15. What concerns you the most about your problem; what does it prevent you from doing?

_____

16. What is your: Height_____ **Weight** _____ **Date of Birth** _____

17. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

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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

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	
□	□	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 Control		□	□	Dermatitis/Eczema/Rash	
□	□	Upper Leg Pain		□	□	Prostate Problems		□	□	HIV/AIDS	
□	□	Knee Pain		□	□	Abnormal Weight Gain/Loss					
□	□	Ankle/Foot Pain		□	□	Loss of Appetite		**For Females Only**			
□	□	Jaw Pain		□	□	Abdominal Pain		□	□	Birth Control Pills	
□	□	Joint Pain/Stiffness		□	□	Ulcer		□	□	Hormonal Replacement	
□	□	Arthritis		□	□	Hepatitis		□	□	Pregnancy	
□	□	Rheumatoid Arthritis		□	□	Liver/Gall Bladder Disorder					
□	□	Cancer		□	□	General Fatigue					
□	□	Tumor		□	□	Muscular Incoordination					
□	□	Asthma		□	□	Visual Disturbances					
□	□	Chronic Sinusitis		□	□	Dizziness					
□	□	Other:_____									

20. List all prescription medications you are currently taking (or submit list):
_____

21. List your allergies to medications:
_____

22. List all of the over-the-counter meds. & vitamins you are currently taking (or submit list):
_____

23. List all surgical procedures you have had (or submit list):
_____

24. 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 day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Drives:**	□ Most of the day	□ Half the day	□ A little of the day

□ **Travel frequently** □ **Perfom manual labor** □ **Read a lot**

25. What activities do you do outside of work?
_____

26. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

27. Have you had significant past trauma? □ No □ Yes

28. Anything else pertinent to your visit today?_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient Signature (or Guardian) _____ Date _____
Doctors Signature _____ Date _____