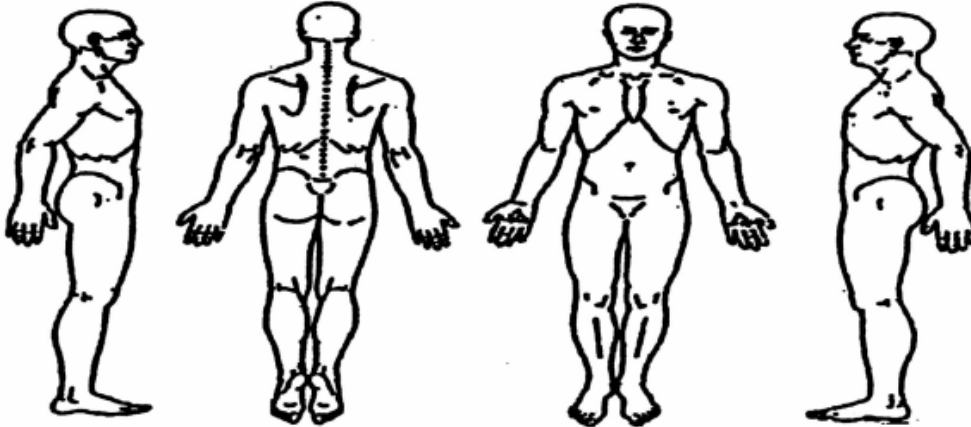


PATIENT INTAKE FORM

Patient Name: _____

Date: _____

1. Indicate on the drawings below where you have pain/symptoms



2. How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

3. How would you describe the type of pain?

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

4. How are your symptoms changing with time?

- Getting Worse
- Staying the Same
- Getting Better

5. 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)

6. How much has the problem interfered with your work?

- Not at all
- Slightly
- Moderately
- Substantially
- Extremely

7. How much has the problem interfered with your social activities?

- Not at all
- Slightly
- Moderately
- Substantially
- Extremely

8. Who else have you seen for your problem?

- Chiropractor
- ER physician
- Massage Therapist
- Neurologist
- Orthopedist
- Physical Therapist
- Primary Care Physician
- Other: _____
- No one

9. How long have you had this problem? _____

10. How do you think your problem began?

11. Do you consider this problem to be severe?

- Yes
- Yes, at times
- No

12. What aggravates your problem?

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

14. What is your: Height _____ Weight _____ Date of Birth _____
Occupation _____

15. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

16. What type of exercise do you do?

- Strenuous Moderate Light None

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

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

18. 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
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		

19. List all prescription medications you are currently taking:

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

21. List all surgical procedures you have had:

22. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

23. What activities do you do outside of work?

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

25. Have you ever been to a chiropractor before? No Yes
if yes, how long ago _____
if yes, were the results Good Mixed Poor

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____