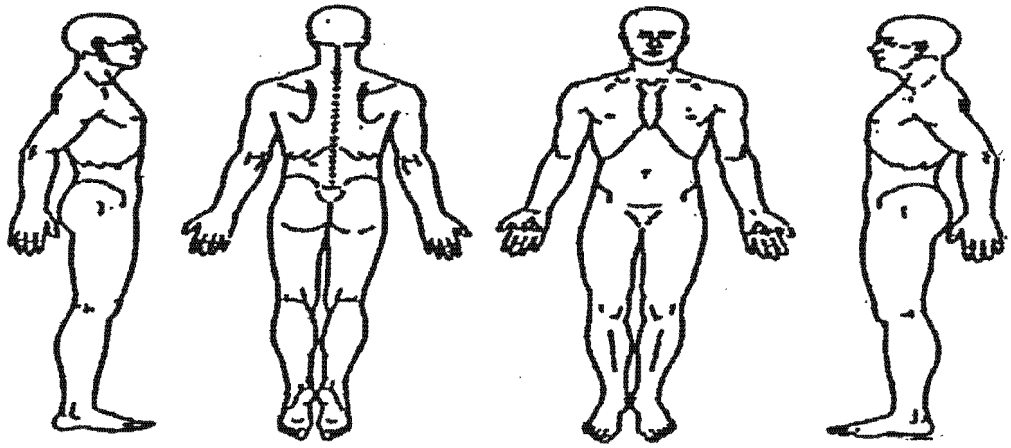
PATIENT INTAKE FORM

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

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 concerns you the most about your problem; what does it prevent you from doing?**

_____

15. What is your: Height_____ Weight _____ DOB _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ 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
□	□ 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:
_____

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 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

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

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

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

27. Anything else pertinent to your visit today?_____

Patient Signature_____ Date:_____