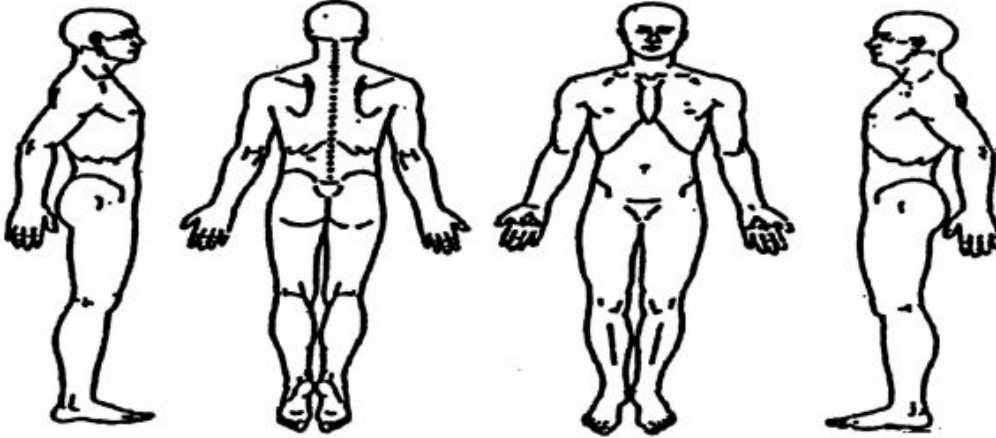


## PATIENT INTAKE FORM

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?

- |   |   |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time)  |
| <input type="checkbox"/> Frequently (51-75% of the time)  | <input type="checkbox"/> Intermittently (1-25% of the time) |

4. How would you describe the type of pain?

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion         |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion      |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____              |

5. How are your symptoms changing with time?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Staying the Same | <input type="checkbox"/> 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?

- |                                     |                                       |                                     |                                      |                                    |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> A little bit | <input type="checkbox"/> Moderately | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Extremely |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|

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

- |                                     |                                       |                                     |                                      |                                    |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> A little bit | <input type="checkbox"/> Moderately | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Extremely |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|

9. Who else have you seen for your problem?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chiropractor      | <input type="checkbox"/> Neurologist        | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician      | <input type="checkbox"/> Orthopedist        | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> 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?

- |                              |  |                             |
|------------------------------|--|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Yes, at times | <input type="checkbox"/> 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 \_\_\_\_\_  
Occupation \_\_\_\_\_

16. How would you rate your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ 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
<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		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

**For Females Only**

☐ Birth Control Pills  
☐ Hormonal Replacement  
☐ Pregnancy

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?

<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

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: \_\_\_\_\_