
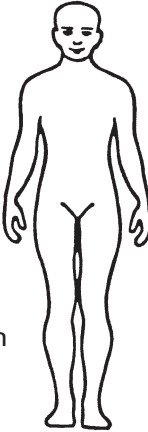


PATIENT INTAKE FORM

Patient Name: _____ Date: _____

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

2. Indicate on the drawings to the right where you have pain/symptoms  **R**  **L**

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 time of pain?

- Sharp Dull Diffuse Achy
 Achy Burning Shooting Stiff
 Numb Tingly Sharp with motion Shooting with motion
 Electric-like with motion 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?

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 No one
 Massage Therapist Physical Therapist Other: _____

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 alleviates 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 Birth _____

17. Occupation _____ Have you missed work? _____

18. How would you rate your overall Health?

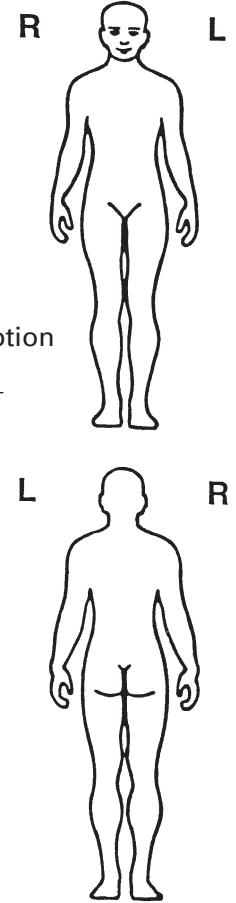
- Excellent Very Good Good Poor

19. What type of exercise do you do?

- Strenuous Moderate Light None

20. 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 the condition listed below, place a check in the "present" column.

Past Present

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Elbow/Upper Arm Pain
- Wrist Pain
- Hand Pain
- Hip Pain
- Upper Leg Pain
- Knee Pain
- Ankle/Foot Pain
- Jaw Pain
- Join Pain/Stiffness
- Arthritis
- Rheumatoid Arthritis
- Cancer
- Tumor
- Asthma
- Chronic Sinusitis
- Other: _____

Past Present

- High Blood Pressure
- Heart Attack
- Chest Pains
- Stroke
- Angina
- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems
- Abnormal Weight Gain/Loss
- Loss of Appetite
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver/Gall Bladder Disorder
- General Fatigue
- Muscular Incoordination
- Visual Disturbances
- Dizziness

Past Present

- Diabetes
- Excessive Thirst
- Frequent Urination
- Smoking/Tobacco Use
- Drug/Alcohol Dependence
- Allergies
- Depression
- Systemic Lupus
- Epilepsy
- Dermatitis/Eczema/Rash
- HIV/AIDS

For Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy

21. List all prescription medications you are currently taking:

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

23. List all surgical procedures you have had:

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes

If yes, why _____

27. Have you had significant past trauma? No Yes

28. Have you previously seen a chiropractor? No Yes

If yes, what were the results? Great Good Fair Mixed Poor Other

28. Anything else pertinent to your visit today? _____

Patient Signature _____

Date: _____