Patient Intake Form

Date _____

Personal Information

First Name: _____ Last Name: _____ Initial _____
Address: _____
City / State / Zip: _____
Home Phone: _____ Work Phone: _____
Mobile Phone: _____ Email: _____
Social Security #: _____ Birth Date: _____ Age: ____Sex: M F
Occupation: _____ **Height: _____ Weight: _____**
Employer's Name: _____ **Right Handed/ Left Handed**
Work Address: _____
City / State / Zip: _____
Marital Status: S M D W
Spouse's Name: _____ # of Children: _____
Age(s) of Children: _____
Major Medical: _____ Policy #_____Group #_____
Primary Holders Information:
First Name: _____Last Name: _____ Birth Date: _____

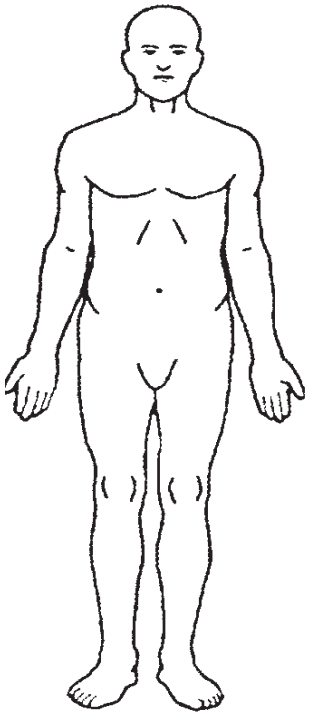
Major Complaint Information

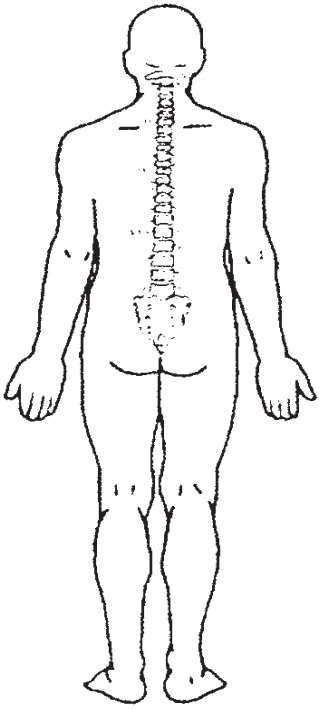
What is your major complaint? _____
When did this symptom(s) begin? _____
If this is an injury, describe what happened (include date, location, and if taken to hospital in ambulance)
_____
_____
_____
_____
_____
_____

Emergency Contact

Name: _____ Relation: _____
Home Phone: _____ Work Phone: _____
Address: _____
City/State/Zip: _____

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain.





Pain Index
D Dull Nagging Ache
B Burning
S Sharp / Stabbing
N Numbness / Tingling

What is the pain interfering with that's most important in your life?_____

SEVERITY

On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain imaginable, use the key to the right to rate the severity of your pain.

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10? (Please circle)

0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? Yes No
When? _____
What aggravates this condition? _____
What decreases the symptoms / pain? _____
Have you seen another doctor for this condition? Yes No
Doctor's Name: _____
Date consulted: _____
Diagnosis: _____

Does this condition interfere with your sleep? Yes No
If so, how many times do you wake up in pain per night? _____
In what position do you sleep? Back Side Stomach
Do you sleep with a pillow? Yes No
How many? _____
Does heat affect the pain? Yes No
If so, how?_____
Does cold affect the pain? Yes No
If so, how? _____
Do you wear a heel lift? Yes No If so, which side? Right Left
Does it cause pain to cough, grunt, or sneeze? Yes No
If so, where? _____

Check those activities below during which you experience difficulty or pain:

0 Lying on back	0 Lying on side	0 Turning over in bed	0 Lying flat on stomach
0 Getting in/out of car	0 Dressing Self	0 Sexual Activity	0 Sneezing
0 Pushing	0 Pulling	0 Reaching	0 Coughing
0 Kneeling	0 Stooping	0 Sitting	
0 Bending forward	0 Bending backward		
0 Walking	0 Standing for long periods		
0 Other:_____			

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

Lower Back Pain

Does pain radiate into the leg? Yes No
Where: _____
Does pain radiate to the abdomen? Yes No
Do you ever have impairment of bowel or urinary function? Yes No
Explain: _____
_____
Do you have numbness or tingling into the legs? Yes No
Explain: _____
_____

Neck Pain

If you have a neck injury, does it affect: (Circle all that apply)
Hearing Vision Balance Cause ringing in your ears
Do you hear grating sounds? Yes No
Do you feel pressure or pain behind your eyes? Yes No
Does pain radiate into the arm? Yes No
Where: _____
Do you have difficulty lifting or turning your head? Yes No
If so, in which direction? Right Left Up Down

Headaches

Do you get headaches? Yes No
Frequency _____
Do you have a family history of headaches? Yes No
Do you experience the following along with your headaches: Pain or cracking in your jaw? Yes No
Abnormal blood pressure? Yes No High Low
Nausea, Vomiting, or Visual disturbances? Yes No
When was your last eye exam by a doctor? 1 - 6 months 6 - 12 months 1 - 2 years over 2 years
Results:_____

If female, are you pregnant? Yes No Not Sure
If no or not sure, date of your last menstrual period:_____

List all medications you are taking now, including over the counter medication.
_____
_____

Are you allergic to any medications? Yes No Not Sure
Please list: _____
_____

Have you ever had any surgeries or hospitalizations? Yes No If yes, Please list:

Type of Hospitalization/Surgery: Date: Type of Hospitalization/Surgery: Date:
_____ _____ _____ _____
_____ _____ _____ _____

Have you been x-rayed or received MRI, CAT scan in the last 12-18 months? Yes No
When?: _____

Have you ever been seen by a chiropractor before? Yes No If yes, Please list:

Name of Chiropractor: Dates: Name of Chiropractor: Dates:
_____ _____ _____ _____
_____ _____ _____ _____

Do you have a family physician? Yes No
Name of physician: _____ _____Phone: _____
Address: _____
City/State/Zip: _____

Additional Complaints

Please circle all additional complaints that you have at this time:

Loss of Concentration	Memory Loss	Fainting
Vision Problems	Eyes Sensitive to Light	Pain Behind Eyes
Heavy Feeling of Head	Dizziness	Excess Perspiration
Ringing in Ears	Palpitation	Jaw pain
Loss of Balance	Loss of Smell	Loss of Taste
Neck Stiffness	Arthritis	Neck Motion Restricted
Sinus Trouble	Nervousness	Upper Back Pain / Stiffness
Chest Pain	Anxiety	Mid Back Pain / Stiffness
Irritable	Fatigue	Low Back Pain/Stiffness
Depression	Insomnia	Right / Left Shoulder Pain
Diabetes	Heart Disease	Right / Left Arm Pain
Convulsions	Hypertension	Right / Left Leg Pain
Anemia	HIV (Aids)	Pins & Needles Arms / Legs
Shortness of Breath	Cold Hands/Feet	Digestive Trouble
Nausea/Vomiting	Diarrhea	Constipation
Allergies (Please List)	Other (Please List)	Please Specify Location:
_____	_____	Numbness _____
_____	_____	Swelling _____
_____	_____	Cuts _____
_____	_____	Bruising _____

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No
If so, please list: _____
_____

Have you ever had? Motor Vehicle Injury Sports Injury Work Injury Slip and Fall Injury
If yes, please explain:
_____

Is there any additional information you would like the doctor to know about before beginning care?
_____
_____
_____

Areas of Interest

Please mark areas of interest or if you desire more information:

____ Nutritional Supplements	____ Neck/Body Pillows	____ Pain Relief
____ Pain Management	____ Decompression	____ Massage
____ Headaches	____ Physiotherapy	____ Physical Therapy
____ Weight Loss Information	____ Wellness Care	____ Others (list)
____ Women's Health	____ Children's Care	_____

Additional Complaint & Location

DESCRIBE LOCATION: _____
_____

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10?
(Please circle) 0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10
What is the most intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10

ASSOCIATED SIGNS AND SYMPTOMS:

How does this symptom affect your movement?
(Please circle) Inflexibility Stiffness Spasms Cramps
Other_____

How would you best describe the sensation of the pain/symptom?

Deadness Prickly Numb Crawling Tingling Stabbing Hurting Pulsating Pins & Needles
Pounding Burning Shooting Throbbing Stinging Dull Sharp Aching Excruciating

Over the past several weeks/months this complaint is: Improving Getting worse About the same

Additional Complaint & Location

DESCRIBE LOCATION:_____
_____

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10?
(Please circle) 0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10
What is the most intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10

ASSOCIATED SIGNS AND SYMPTOMS:

How does this symptom affect your movement?
(Please circle) Inflexibility Stiffness Spasms Cramps
Other_____

How would you best describe the sensation of the pain/symptom?

Deadness Dull Aching Excruciating Sharp Prickly Numb Crawling Tingling
Stabbing Hurting Pulsating Pins & Needles Pounding Burning Shooting Throbbing Stinging

Over the past several weeks/months this complaint is: Improving Getting worse About the same

Social History

Frequency of Exercise Never Rarely Occasionally Moderately Regularly
Intensity of Exercise Low Medium High Competitive
Sufficient Rest Never Rarely Occasionally Moderately
On average, how many hours of sleep do you get per night? _____
Well balanced diet? Never Rarely Occasionally Moderately
Do you smoke? No Occasionally 1 to 2 2 to 3 packs/day
Do you drink caffeinated beverages? No Occasionally 3 to 5 More than 5 drinks/day
Do you drink alcoholic beverages? No Occasionally 1 to 2 More than 3 drinks/day
Have you ever used street drugs? Yes No
What do you enjoy doing most when you are not working? _____
_____
_____
_____

Family History

Genetics have an influence on health **and** sickness. Please indicate family members, (parents, siblings, grandparents, aunts and uncles) past or present, with any of the following conditions:

Back Pain _____ Neck Pain _____
Headaches _____ Sleep Disorders _____
Heart disease _____ Stroke _____
Diabetes _____ High Blood Pressure _____
Asthma/COPD _____ High Cholesterol _____
Cancer _____ Alcoholism _____

Depression _____ Suicide _____
Genetic disorders _____ Bleeding disorders _____

Pain Rating Scale

Please indicate how much pain you have: In order to check how your treatment is progressing, your Doctor will often ask you to rate your pain level on this diagram/scale from zero (0) to ten (10). A rating of zero (0) means you feel no pain; five (5) means you feel a moderate amount of pain; and ten (10) means you feel the severe/worse pain imaginable.

Please circle the number you feel that best describes your pain level.