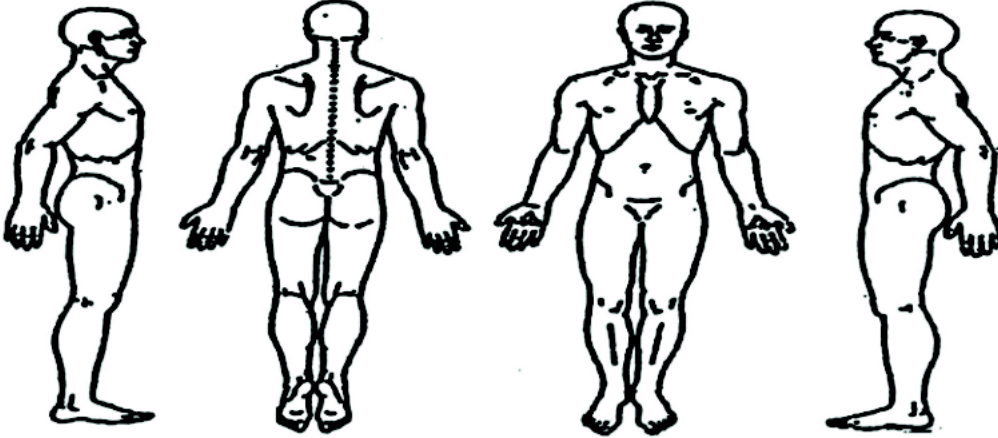


# PATIENT INTAKE FORM

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 \_\_\_\_\_ 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		<b>For Females Only</b>
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<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: _____				

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: \_\_\_\_\_

# Patient Health History

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Today's Date  /  Signature of Patient \_\_\_\_\_

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Home email \_\_\_\_\_ Work Email \_\_\_\_\_

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

Which email address would you like us to use to communicate with you? (check one)  Home  Work

Contact Method (check one)

Primary Phone  Secondary Phone  Mobile Phone  Home Email  Work Email

Date of Birth  /  Age \_\_\_\_\_ Gender (check one)  Male  Female  Unspecified

Marital Status (check one)  Single  Married  Other SSN \_\_\_\_\_

Employment Status (check one)

Employed  FT Student  PT Student  Other  Retired  Self Employed

Race (check one)

White  Black/African American  Hispanic  American Indian/Alaskan Native  
 Asian  Asian Indian  Chinese  Filipino  
 Japanese  Korean  Vietnamese  Native Hawaiian or other Pacific Island  
 Samoan  Guamanian or Chamorro  Other \_\_\_\_\_  I choose not to specify

Multi-Racial (check one)  Yes  No  Unknown

Ethnicity (check one)  Hispanic or Latino  Not Hispanic or Latino  I choose not to specify

Preferred Language (check one)

English  Spanish  American Sign Language  Chinese  French  German  
 Tagalog  Vietnamese  Italian  Korean  Russian  Polish  
 Arabic  Portuguese  Japanese  French Creole  Greek  Hindi  
 Persian  Urdu  Gujarati  Armenian  I choose not to specify

Continued ...

**Verification Question** (choose only one question by circling the question, then give the answer to that question)

- What is the name of your favorite pet?   
  In what city were you born?   
  What high school did you attend?  
 What is your favorite movie?   
  What is your mother's maiden name?   
  On what street did you grow up?  
 What was the make of your first car?   
  When is your anniversary?

**Verification Answer to the Chosen question:** \_\_\_\_\_

*Answers must be at least 6 characters.*

**Do you currently smoke tobacco of any kind?**   
 Yes   
 Former smoker   
 Never been a smoker

**If yes, how often do you smoke:**   
 Current every day smoker   
 Current sometimes smoker

**If yes, what is your level of interest in quitting smoking?**

- 0   
 1   
 2   
 3   
 4   
 5   
 6   
 7   
 8   
 9   
 10  
*No interest* *Very Interested*

**Current medications, including frequency and dosage if known. If there are no current medications, check here:**

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

**List any known allergies you have had to any medications.**

**If no allergies are known, check here:**

- 1) \_\_\_\_\_    3) \_\_\_\_\_  
 2) \_\_\_\_\_    4) \_\_\_\_\_

**Briefly list your main health problems:** \_\_\_\_\_  
 \_\_\_\_\_

**Has any doctor diagnosed you with Hypertension presently?**   
 Yes   
 No   
 If yes, describe: \_\_\_\_\_  
 \_\_\_\_\_

**Has any doctor diagnosed you with Diabetes presently?**   
 Yes   
 No   
 If yes, what kind?   
 Type I   
 Type II  
***If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?***   
 Yes   
 No   
 Not Sure  
***If yes, other comments regarding Diabetes:*** \_\_\_\_\_

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?**   
 Yes   
 No

**To be performed by clinic staff:**

**Height:** \_\_\_\_\_ inches   
**Weight:** \_\_\_\_\_ pounds   
**BP:** \_\_\_\_\_ / \_\_\_\_\_