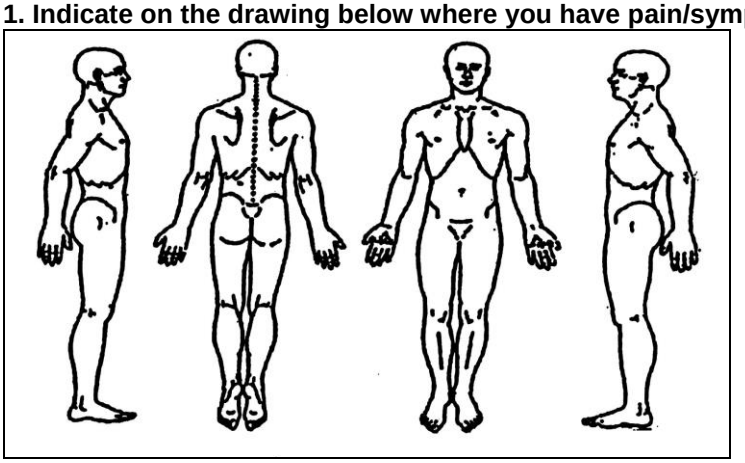
Patient Intake Forms

Name_____ SS#_____ DOB_____/_____/_____
Address (1) _____ Address (2)_____
City _____ State_____ Zip_____ Marital Status_____ Sex: □M □F
Do you prefer calls at: □Home □Work □Cell □No preference
Home # (_____) _____ Work # (_____) _____ Cell # (_____) _____
Email _____ May we notify you via email of various office promotions? □Y □N
Patient Employer/School_____ Occupation_____
Emergency Contact _____ Phone (___) _____
Whom may we thank for referring you to our office?_____

Primary Insurance Carrier_____ Name of Policy Holder_____
Relationship to Policy Holder_____ Policy Holder DOB _____/_____/_____
Policy #:_____ Group #:_____
Secondary Insurance Carrier_____ Primary Policy Holder_____
Relationship to Policy Holder_____ Policy Holder DOB _____/_____/_____
Policy #:_____ Group #:_____

1. Indicate on the drawing below where you have pain/symptoms



BP_____/_____ **Height**_____ **Weight**_____
Flu Shot □ No □ Yes
Ethnicity: □Hispanic or Latino □Not Hispanic or Latino
Race: □White □Black/African American
□American Indian/Alaskan Native
□Native Hawaiian/Pacific Islander □2 or more
Preferred Language:
□English □Spanish □French □German □ Italian
□Mandarin □Cantonese □Tagalag □Japanese □Other
Smoking Status □Daily □Some days □Former □Never
Are you allergic to any medicines? □ No □ Yes
Medication_____ **Symptom**_____
Have you ever been diagnosed with:□Asthma □Diabetes

3. How often do you experience your symptoms?
□ Constantly (76-100%) □ Frequently (51-75%) □ Occasionally (26-50%) □ Intermittently (1-25%)
4. How would you describe the type of pain?
□ Dull □ Achy □ Stiff □ Sharp □ Shooting □ Numb □ Tingly □ Burning □ Sharp with motion
□ Shooting with motion □ Stabbing with motion □ Electric like with motion □ Other:_____
5. How are your symptoms changing with time? □ Getting Worse □ Not Changing □ 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?
□ Primary Care Physician □ Chiropractor □ ER physician □ Neurologist
□ Orthopedist □ Physical Therapist □ Massage Therapist □ No one □ Other: _____
9a. Have you had any special imaging, x-rays, or MRI's? □Yes □No Date ____/____/_____Location_____
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
13a. What aggravates your problem (makes it worse)?_____
13b. What alleviates your problem (makes it better)?_____
14. What concerns you most about your problem?

□Could be serious □Not going away □Affecting work □Affecting sleep □Getting worse □Other_____

15. 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 the appropriate column "past" or "present".

Past Present	Past Present	Past Present
□ □ Headaches	□ □ Chronic Sinusitis	□ □ Visual Disturbances
□ □ Neck pain	□ □ High blood pressure	□ □ Dizziness
□ □ Upper back pain	□ □ Heart attack	□ □ Diabetes
□ □ Mid back pain	□ □ Chest pains	□ □ Excessive thirst
□ □ Low back pain	□ □ Stroke	□ □ Frequent urination
□ □ Shoulder pain	□ □ Angina	□ □ Smoking/Tobacco
□ □ Elbow pain	□ □ Kidney stones	□ □ Drug/Alcohol
□ □ Wrist pain	□ □ Kidney disorders	□ □ Allergies
□ □ Hand pain	□ □ Bladder infection	□ □ Depression
□ □ Hip pain	□ □ Painful urination	□ □ Systemic lupus
□ □ Upper leg pain	□ □ Loss of bladder control	□ □ Epilepsy
□ □ Knee pain	□ □ Abnormal weight change	□ □ Dermatitis/Eczema/Rash
□ □ Ankle/Foot pain	□ □ Loss of appetite	□ □ Prostate problems
□ □ Jaw Pain	□ □ Abdominal Pain	□ □ HIV/AIDS
□ □ Joint Pain/Stiffness	□ □ Ulcer	
□ □ Arthritis	□ □ Hepatitis	**For Females Only**
□ □ Rheumatoid Arthritis	□ □ Liver/Gall Bladder Problem	□ □ Birth Control Pills
□ □ Cancer	□ □ General Fatigue	□ □ Hormonal Replacement
□ □ Tumor	□ □ Muscular Incoordination	□ □ Pregnancy
□ □ Asthma		

20. Medication	**#Refills**	**#Pills**	**Strength (mg)**	**Dose Form(i.e. capsule)**	**Instruction (i.e. 1 per day)**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

21. Supplements/over-the-counter medications:_____

22. List all major 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 the day	□ A little of the day
□ **Drives:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Manual Labor:**	□ Most of the day	□ Half the day	□ A little of the day

24. What activities, sports, hobbies do you do outside of work?_____

25. Have you ever been hospitalized? □ No □ Yes **Why?**_____

26. Have you seen a chiropractor before □ No □ Yes **When?**_____/_____/_____

26a. Results □ Great □ Good □ Fair □ Mixed □ Poor □ Other

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

29. Anything else pertinent to your visit today? □ No □ Yes _____

I would like to electronically have access to my health information: **(Please initial)** _____

Patient Signature_____ **Date:**_____/_____/_____