ROCKRIDGE FAMILY CHIROPRACTIC

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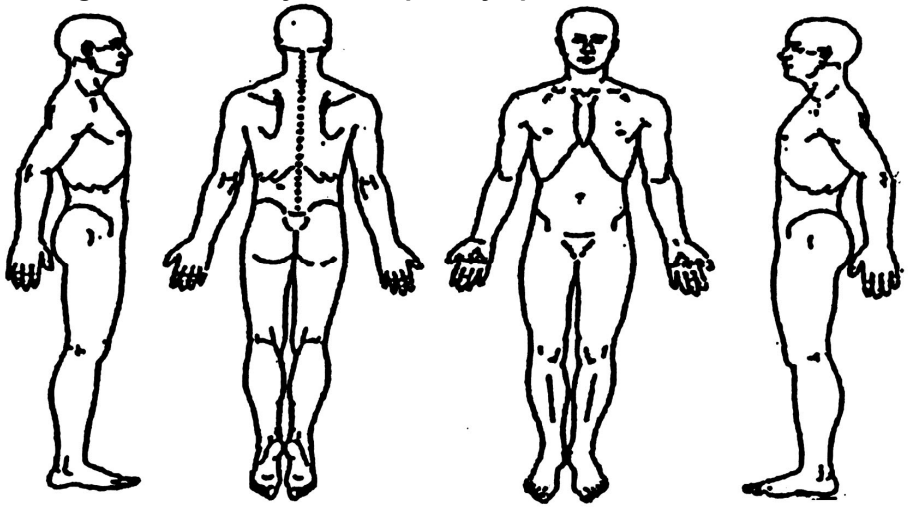
PATIENT INTAKE FORM

Patient Name(Please Print): _____ Date: _____

1. Is today's problem caused by: ☐ Auto Accident ☐ Work ☐ Other_____

2. Indicate on the drawings below where you have pain/symptoms



No pain=0 1 2 3 4 5 6 7 8 9 10=Unbearable

3. Please, list your symptoms in order of concern:	**Rate the severity 0 -10**	**How Often (0% to 100% of the day)**
1_____	_____	_____
2_____	_____	_____
3_____	_____	_____
4_____	_____	_____
5_____	_____	_____
6_____	_____	_____

4. How would you describe the type of pain for each symptom (indicate symptom from numbers in 2a)?

☐ 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. How much has the problem/s interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

7. How much has the problem/s interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐Quite a bit ☐ Extremely

8. Who else have you seen for your problem/s?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER physician ☐ Orthopedist ☐ Other:_____
☐ Massage Therapist ☐ Physical Therapist ☐ No one

9. How long have you had this problem/s? _____

10. How do you think your problem/s began and do you think it is severe?(Please specify for each problem.)

_____

11a. What activities/things seem to make your problem/s worse?(Please specify for each problem, if applicable.)

_____

11b. Is there anything you can do (or take) to make your problem/s feel better? (If yes, what?)

_____

12. Do you have any concerns regarding your problem/s (not going away, affecting normal activities, etc.)?

_____

13. Height _____ Weight_____

14. Indicate if you have any immediate family members with any of the following (mother/father/sister/brother):

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

15. 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
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking/Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/ Arm Pain	☐	☐ Kidney Disorders	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Abnormal Weight Gain/Loss		
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite	**For Females Only**	
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐ Birth Control Pills
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	☐	☐ Hormonal Replacement
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Pregnancy
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder Disorder		
☐	☐ Cancer	☐	☐ General Fatigue		
☐	☐ Tumor	☐	☐ Muscular Incoordination		
☐	☐ Asthma	☐	☐ Visual Disturbances		
☐	☐ Chronic Sinusitis	☐	☐ Dizziness		
☐	☐ Other:_____				

16. List all prescription medications you are currently taking:

_____

16a. List all medications you are allergic to and their effects (hives, swelling, coughing etc) and severity:

_____

17. List all of the supplements you are currently taking:

_____

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

_____

19. List all surgical procedures you have had:

_____

20. How would you rate your overall health? **Excellent** **Very Good** **Good** **Fair** **Poor**

21. What kind of regular exercise do you perform? **Strenuous** **Moderate** **Light** **None**

22. What do you do at work most of the day?_____

23. What do you do outside of work? _____

24. Have you seen a chiropractor before? If yes, how long ago and what were the result (great, good, fair, mixed, poor, other)?_____

25. Have you been hospitalized before? If yes, for what and when?

_____

26. Have you had significant past trauma? □ No □ Yes
explain_____

27. Anything else pertinent to your visit today you need to tell us?

_____

Patient Demographics:

The Department of Health/Medicare request we collect the following demographic information. Answering these questions is strictly voluntary and is for statistical purposes only:

Ethnicity: *(Please circle)*

Hispanic or Latino	Not Hispanic or Latino

Race: (Please circle)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	Two or more

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other_____

Smoking Status:				
	Smokes every day	Smokes some days	Former Smoker	Never Smoke

Have you been diagnosed with: (Please circle)

Asthma?	Diabetes?

Patient Signature_____ **Date:**_____