

# Patient Intake

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1. First Name:

Last Name:

DOB:

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2. MRN #:

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## PATIENT INTAKE

Welcome to our online intake form. The information you fill in will be sent directly to our office, speeding up your office visit and allowing us to better serve your healthcare needs.

## ABOUT YOU

### 3. Home Address

Address 1

Address 2

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City

State

Zip Code

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### 4. Contact Information

Mobile Phone

Home Phone

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Primary Email Address

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### 5. Demographic Information

Sex at birth:

Male  Female

Marital Status:

Single  Married  Divorced  Widowed  Other

### 6. Spouse's Name:

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### 7. Number of Children:

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### 8. Personal Information

Height - Feet:

Height - Inches:

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Weight (in pounds):

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**9. Do you have insurance?**

Yes

No

**10. Insurance Payer**

Insurance Payer

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**11. Insurance Policy Information:**

Insurance Plan Name

ID/Policy Number:

Group Number:

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Relationship to Patient:

Self  Spouse  Parent  Employer  Caregiver  Other

Insured's First & Last Name:

Insured's Date of Birth:

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**12. Insurance Card Upload**

**13. Emergency Contact Information**

Emergency Contact Name:

Contact Phone Number:

Relationship to Patient:

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**14. Employer Information**

Employment Status:

Employed  Student  Not Employed  Retired  Unknown

Employer Name:

Occupation:

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Physical Work Duties:

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**15. Referral Information**

Referring Physician:

Referring Patient:

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How did you hear about us?

Word of mouth  Advertisement  Social media  Direct mail or email campaign  Event  Internet

Other:

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## VISIT PURPOSE

**16. Select the main reason for this visit:**

- Auto Accident (job related)     Auto Accident (personal)     Work Injury (not auto related)  
 Other (not related to an auto accident or work injury)

## AUTO ACCIDENT

**17. When did the accident occur?**

\_\_\_\_\_

Where in the vehicle were you at the time of the accident?

\_\_\_\_\_

In what direction were you looking at the time of impact?

**18.**

	Yes	No/Unsure
Were you wearing a seatbelt?		
Did the airbag deploy?		
Did you come in contact with anything at the time of the collision?		
Did you receive an injury to the head?		
Did you lose consciousness?		
Did your head hit the headrest?		

**19. Which part of your vehicle was impacted? Choose all that apply.**

	Yes	No
Front right		
Front left		
Front head on		
Rear end- center		
Rear right		
Rear left		
Right side (passenger's side)		
Left side (driver's side)		
Unknown		

**20. In what direction was your vehicle moving?**

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What was the approximate speed of your vehicle?

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What was the extent of the damage to your vehicle?

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In what direction was the other vehicle moving?

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What was the approximate speed of the other vehicle?

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What was the extent of the damage to the other vehicle?

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21.		Yes	No
	Was your vehicle towed from the scene?		
	Did police arrive at the scene?		
	Was an accident report taken?		
	Did Emergency Medical Services arrive at the scene?		

22. How did you leave the scene of the accident?

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23. Where was discomfort felt immediately following the accident? Choose all that apply.

	Yes	No
Abdomen		
Back		
Chest		
Face		
Head		
Neck		
Right shoulder, elbow, arm or hand		
Left shoulder, elbow, arm or hand		
Right hip, thigh, knee, leg or foot		
Left hip, thigh, knee, leg or foot		

24. Are you working with an attorney?

Yes

No

# WORK INJURY

25. What type of accident caused your injury?

- Bending
- Carrying
- Climbing
- Crawling
- Jumping
- Kneeling
- Lying down
- Lifting
- Pulling
- Pushing
- Raising arm(s) above shoulder(s)
- Running
- Performing repetitive motions
- Sitting
- Squatting
- Prolonged Standing
- Talking on the phone
- Traveling
- Turning
- Twisting
- Typing
- Using a computer
- Walking
- Other job related activity
- Other non-job related activity

When did the accident occur?

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26.

	Yes	No
Did you receive an injury to the head?		
Did you lose consciousness?		
Did police arrive at the scene?		
Was an accident report taken?		
Did Emergency Medical Services arrive at the scene?		

27. How did you leave the scene of the accident?

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28. Where was discomfort felt immediately following the accident? Choose all that apply.

	Yes	No
Abdomen		
Back		
Chest		
Face		
Head		
Neck		
Right shoulder, elbow, arm or hand		
Left shoulder, elbow, arm or hand		
Right hip, thigh, knee, leg or foot		
Left hip, thigh, knee, leg or foot		

## AREAS OF CONCERN

29. What is your primary area of concern? We will ask about additional complaints after we gather information about this first area of concern.

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30. What term(s) describes your discomfort after the accident? Choose all that apply.

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

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31. What treatment, if any, have you received since the accident? Choose all that apply.

	Yes	No
Hospitalization		
Surgery		
Acupuncture		
Chiropractic care		
Injection therapy		
Massage		
Naturopathic medicine		
Physical therapy		
Primary care physician visit		
Over-the-counter medications		
Prescribed medications		
Heat or cold therapy		
None		
Other		

If other, specify:

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32. Are there any additional symptoms which have appeared since the accident occurred? Choose all that apply.

	Yes	No
Breathing difficulty		
Muscle spasm		
Chest pain		
Numbness and tingling		
Depression		
Rib pain		
Facial pain		
Stomach pain		
Genital pain		
Headaches		
Tightness		
Soreness		
Shock		
Dizziness		
Sleeping difficulty		
Stress		
Gluteal pain		
Irritability		
Stunned		
Tiredness		
Loss of appetite		
Anxiety		
Low energy		
None		
Other		

If other, specify:

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33. Have your symptoms changed since the accident? Choose all that apply.

	Yes	No
Improved daily functioning at home/work		
Shown no change in daily functioning at home/work		
Deteriorated daily functioning at home/work		
Symptoms have exacerbated		
Symptoms have disappeared		
Elicited more pain		
Elicited more stiffness		

34. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

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How often do you feel this discomfort?

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35. Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

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**36. What aggravates this condition? Choose all that apply.**

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		
Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

**If other, specify:**

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37. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Nothing		
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over-the-counter medications		
Physical therapy		
Other		

If other, specify:

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38. Have other health care provider(s) performed tests related to this condition?

- Yes  No

If Yes, specify:

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39. Have you ever had any previous episodes of this condition?

- Yes  No

If Yes, specify:

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40. Do you have an additional condition?

- Yes  No

If Yes, specify:

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## AREAS OF CONCERN

41. Approximate date this condition began (exact date not required)

What caused this condition?

What is your primary area of concern? We will ask about additional complaints after we gather information about this first area of concern. Describe primary body area of concern:

42. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

43. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

How often do you feel this discomfort?

How has this complaint changed since onset?

Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

44. What treatment, if any, have you received since the injury? Choose all that apply.

	Yes	No
Chiropractic care		
Massage		
Medical injection treatment		
Surgical treatment		
Over-the-counter medications		
Prescribed medications		
Natural or holistic treatment		
Acupuncture		
Physical therapy		
None		
Other		

If other, specify:

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45. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		
Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

If other, specify:

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46. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over-the-counter medications		
Physical therapy		
Nothing		
Other		

If other, specify:

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47. Have other health care provider(s) performed tests related to this condition?

- Yes  No

If Yes, specify:

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48. Have you ever had any previous episodes of this condition?

- Yes  No

If Yes, specify:

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49. Do you have an additional condition?

- Yes  No

## ADDITIONAL AREA OF CONCERN

50. Approximate date this condition began (exact date not required)

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What caused this condition?

What is your additional area of concern?

51. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

52. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

How often do you feel this discomfort?

How has this complaint changed since onset?

Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

53. What treatment, if any, have you received since the injury? Choose all that apply.

	Yes	No
None		
Chiropractic care		
Massage		
Medical injection treatment		
Surgical treatment		
Over-the-counter medications		
Prescribed medications		
Natural or holistic treatment		
Acupuncture		
Physical therapy		
Other		

If other, specify:

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54. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		
Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

If other, specify:

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55. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Nothing		
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over-the-counter medications		
Physical therapy		
Other		

If other, specify:

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56. Have other health care provider(s) performed tests related to this condition?

- Yes  No

57. Have you ever had any previous episodes of this condition?

- Yes  No

## CURRENT HEALTH

58. Are you currently taking any medications?

- Yes  No

59. Please list regularly used prescription and over-the-counter medications taken, as well as the Dosage and Frequency for each medication (e.g. 5 mg once daily)

	Medication Name	Dosage/Frequency
1		
2		
3		

60. Other than the condition(s) already shared, do you have any additional health concerns?

	Yes	No
Muscles, Bones or Joints		
Nerves, Headaches, Dizziness, or Emotional		
Head, Eyes, Ears, Nose or Throat		
Heart, Blood Pressure, or Circulation		
Shortness of Breath, Coughing, Asthma or Lung Condition		
Stomach, Bowels or Digestive Conditions		
Genital, Bladder, or Urinary Conditions		
Diabetes, Thyroid or Glandular Condition		
Skin or Bleeding Conditions		
Do you have any medication allergies?		

61. If you have answered yes to any of the above, please share this info with your doctor.

62. Medication Allergies

	Medication Name	Reaction	Onset Date	Additional Comments
1				
2				
3				

## PERSONAL AND FAMILY HISTORY

63.		Yes	No
	Have you had any surgical procedures?		
	Are there any past illnesses or conditions we should be aware of?		
	Do you have a past history of accidents or trauma?		
	Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?		

64. If you have answered yes to any of the above, please share this info with your doctor.

## WORK, SOCIAL, HABITS

65. Current work habits - Choose all that apply.

- Permanently fully disabled  
 Permanently partially disabled  
 Cannot work due to current condition  
 Full-time (20-40+ hours/week)  
 Part-time (1-19 hours/week)  
 Retired  
 Student  
 Homemaker  
 Unemployed

66. Personal social habits

	Yes	No
Smoke or use tobacco products		
Drink alcohol		
Drink caffeine		
Use recreational drugs		
Other, to be discussed with doctor		

67. Present exercise habits

	Yes	No
No current exercise		
Exercise daily		
Exercise 3+ times per week		
Cannot return to exercise due to current condition		

68. Diet and nutrition habits

	Yes	No
Vegan or vegetarian		
Daily supplements		
Other		

69. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

70. \_\_\_\_\_

71. \_\_\_\_\_

**72. Pain Intensity**

- (0) No Pain (0/10)
- (1) Mild Pain (1-3/10)
- (2) Moderate Pain (4-6/10)
- (3) Severe Pain (6-8/10)
- (4) Worst Possible Pain (9-10/10)

**73. Sleeping**

- (0) Perfect sleep; No pain present
- (1) Mildly disturbed sleep from pain
- (2) Moderately disturbed sleep from pain
- (3) Greatly disturbed sleep from pain
- (4) Totally disturbed sleep

**74. Personal Care (washing, dressing, etc.)**

- (0) No pain; no restrictions
- (1) Mild pain; no restrictions
- (2) Moderate Pain; need to go slowly
- (3) Moderate pain; need some assistance
- (4) Severe pain; need 100% assistance

**75. Travel (driving, etc.)**

- (0) No pain on long trips
- (1) Mild pain on long trips
- (2) Moderate pain on long trips
- (3) Moderate pain on short trips
- (4) Severe pain on short trips

**76. Work**

- (0) Can do usual work plus unlimited extra work
- (1) Can do usual work; no extra work
- (2) Can do 50% of usual work
- (3) Can do 25% of usual work
- (4) Cannot work

**77. Recreation**

- (0) Can do all activities without pain
- (1) Can do most activities without pain
- (2) Can do some activities without pain
- (3) Can do a few activities without pain
- (4) Cannot do any activities

## 78. Frequency of Pain

- (0) No pain
- (1) Occasional pain; 25% of the day
- (2) Intermittent Pain; 50% of the day
- (3) Frequent pain; 75% of the day
- (4) Constant pain; 100% of the day

## 79. Lifting

- (0) No pain with heavy weight
- (1) Increased pain with heavy weight
- (2) Increased pain with moderate pain
- (3) Increased pain with light weight
- (4) Increased pain with any weight

## 80. Walking

- (0) No pain; any distance
- (1) Increased pain after 1 mile
- (2) Increased pain after 1/2 mile
- (3) Increased pain after 1/4 mile
- (4) Increased pain with all walking

## 81. Standing

- (0) No pain after several hours
- (1) Increased pain after several hours
- (2) Increased pain after 1 hour
- (3) Increased pain after 1/2 hour
- (4) Increased pain with any standing

## 82. Mark on the image below where you feel pain, numbness, or tingling

