# Patient Intake Questionnaire

Barcode/Z #:

**Name:** ________________________________ **Today's Date:** __________

**Reason For Visit:**

❑ Pain Symptoms ❑ Wellness Visit ❑ Auto Accident
❑ Work Related Injury ❑ Sports Injury ❑ Other Injury

**Date of Injury:** ____________________

## ❑ Auto Accident:

❑ Driver ❑ Passenger, Front ❑ Passenger, Rear ❑ Pedestrian

Were You Wearing Seat Belt? ❑Yes ❑No Did You Receive Aid at Scene? ❑Yes ❑No
Is there a Police Report? ❑Yes ❑No Were You Taken to Hospital? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Type of Car? _________________Year? _______ Was the Car Driveable? ❑Yes ❑No

Did You Hit? ❑Air Bag ❑Steering Wheel ❑Side Door ❑Dashboard ❑Windshield

Describe the Accident: ____________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## ❑ Work Related Injury:

Job Title: ____________________ Company: ________________________ How long? _______

Describe Your Normal Work Activities: ______________________________________________

Did You File a Report? ❑Yes ❑No Were You Taken to Hospital? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Explain in Detail What Caused the Injury: ___________________________________________

______________________________________________________________________________

______________________________________________________________________________

## ❑ Sports or Other Injury:

Explain in Detail What Caused the Injury: ___________________________________________

______________________________________________________________________________

______________________________________________________________________________

Where Did the Injury Occur? _______________________________________________________

Did You File a Report? ❑Yes ❑No Were You Taken to Hospital? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

**Primary Symptoms:** (Check all that apply)

| | | | | |
|---|---|---|---|---|
| Headache | Migraines | Neck Pain | Neck Stiffness | Shoulder Pain |
| Arm Pain | Low Back Pain | Hip Pain | Leg Pain | Back Pain |
| Soreness | Discomfort | Numbness | Tingling | Dizziness |
| Fatigue | Weakness | Memory Loss | Hearing Loss | Depressed |
| Elbow Pain | Knee Pain | Fever | Sweating | Sleep Problems |

Other: ______________________________

**Additional Symptoms:** ______________________________________________________

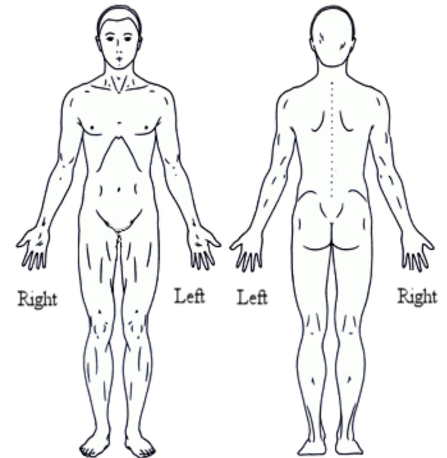
______________________________________________________________________

**Where Specifically Does it Hurt?** (Check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Neck | Upper Back | Mid Back | Lower Back | Left Hip | Right Hip |
| Left Shoulder | Right Shoulder | Left Arm | Right Arm | Left Elbow | Right Elbow |
| Left Leg | Right Leg | Left Knee | Right Knee | Left Ankle | Right Ankle |
| Head | Eyes | Ears | Chest | Abdomen | Buttocks |

Other: __________________________

**Please Describe the Pain and Place an "X" on the Picture:**




**Severity:**
Mild Mild-to-Mod Moderate Mod-to-Severe Severe

**Frequency:**
Once Intermittent Occasional Frequent Constant

**Quality:**
Dull Medium Sharp Stabbing Burning

**The Pain is worse**: (Check all that apply)
Morning Midday After Work Evening Nighttime

**Describe on a Scale of 1 (mild) to 10 (severe) How You Feel:**

Circle One: 1 2 3 4 5 6 7 8 9 10

**Have you Been Treated for this Current Condition in the Past?**

❑ Yes ❑ No When? ___________ By Whom? ___________________________________

**What Activities of Daily Living are you unable to perform due to your pain?**

| | | | | | |
|---|---|---|---|---|---|
| Sleeping | Walking | Standing | Sitting | Running | Climbing |
| Bathing | Showering | Dressing | Shoes | Toileting | Cleaning |
| Self Care | Family Care | Child Care | Home Care | Driving | Gardening |
| Working | Lifting | Desk Work | Traveling | School | Concentrate |

**Describe how the pain affects these Activities of Daily Living:**

______________________________________________________________________

**Check the box that describes the pain and Activities of Daily Living (ADL):**

| 1 – | 2 – | 3 – | 4 – | 5 – | 6 – | 7 – | 8 – | 9 – | 10 – |
|---|---|---|---|---|---|---|---|---|---|
| No Pain | Slight Discomfort | Pain with No Effect on ADL's | Pain with a Little Effect on ADL's | Pain Prevents Any ADL's | Pain Limits Work and Prevents Any ADL's | Pain Prevents Both Work and ADL's | Pain Prevents Working, ADL's and Activity | Pain Keeps Me in Bed or Sitting at All Times | Pain is Horrible, Cannot Tolerate Movement |

Which hand is dominant? Right Left How old is your current mattress? ________________________

What type of bed do you sleep on? Regular Firm Water (full wave) Water (waveless)

What positions do you sleep in? back right side left side stomach floor chair

Previous chiropractor? Dr. __________________ Last visit & reason __________________________________

Family doctor? Dr. __________________ Last visit & reason __________________________________

Other physicians seen or tests performed concerning your main complaint:

Orthopedic Osteopath Physical Therapy Neurologist Podiatrist Dentist OB/GYN MRI Xrays

CAT Scan Nerve Conduction Homeopathy Massage Therapist Other Chiropractor

## ADDITIONAL COMPLAINTS: ______________________________________________________________

______________________________________________________________________________________

## PAST HISTORY:

**What other conditions have you been treated for?** (Explain in detail)

______________________________________________________________________________________

______________________________________________________________________________________

**What Surgeries or Procedures have you had?** (Explain in detail)

______________________________________________________________________________________

**Medical History** – (Check all that apply)

**You:**

| | | | | | |
|---|---|---|---|---|---|
| Diabetes | Arthritis | AIDS | Sciatica | Bursitis | Osteoporosis |
| Alzheimer | Kidney Dis. | Gout | Amputation | Ulcers | High Blood Pressure |
| Cancer | Heart Attack | Stroke | COPD | Scoliosis | Low Blood Pressure |
| Ulcers | Deafness | Blindness | Migraines | Disc Disorder | Neuralgia |
| Constipation | Diarrhea | Nausea | Vomiting | Varicose Vein | Convulsions |
| Fainting | Sweats | Chills | Nervousness | Eczema | Prostate Trouble |
| Bleeding | Tonsillitis | Earache | Hemorrhoids | Pregnancy | Neuro-Muscular Disease |

Other: (Be specific) ________________________________________________________________

**Your Family:**

______________________________________________________________________________________

## List any Current Allergies: (Be specific)

______________________________________________________________________________________

## Current Medications You are Taking: (Be specific)

______________________________________________________________________________________

## Social Activities:

Smoke Cigarettes _____ # packs per day Smoke Cigars I don't smoke

Drink Alcohol Beverages ___ # per day, or ___ # per week I don't drink alcohol.

Beer Wine Mixed Drinks

I admit to history of Recreational Drug Use. I deny history of Recreational Drug Use.

I am currently Pregnant. Due Date: ___________

I exercise regularly.

I experience frequent stress.

## Comments: __________________________________________________________________

______________________________________ ______________________________________

(Your Signature) (Date) Corey A. Brumbaugh, DC (Date)