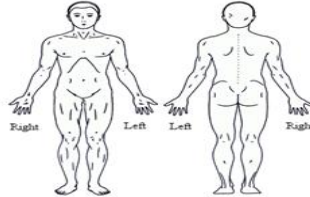


Patient Intake Form

Patient Name: _____

1. Is today's problem caused by:
- Auto Accident Other
- 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 Tingly
- Dull Sharp with motion
- Diffuse Shooting with motion
- Achy Stabbing with motion
- Burning Electric like with motion
- Stiff Other: _____
- Numb
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? (Please circle)
- 0 1 2 3 4 5 6 7 8 9 10
7. How much as the problem interfered with your work?
- Not at all Moderately Extremely
- A little bit Quite a bit
8. How much has the problem interfered with your social activities?
- Not at all Moderately Extremely
- A little bit Quite a bit
9. Who else have you seen for your problem?
- Chiropractor Neurologist Primary Care Physician
- ER physician Orthopedist
- Massage Therapist Physical Therapist Other: _____
- No one
10. Who is your family doctor? _____ May we contact them? ___yes ___no
11. How long have you had this problem _____
12. How do you think your problem began? _____
13. Do you consider this problem to be severe?
- Yes Yes, at times No
14. What aggravates your problem? _____
15. What alleviates your problem? _____
16. What concerns you the most about your problem; what does it prevent you from doing?
- _____
17. What is your: Height _____ Weight _____
18. How would you rate your overall health?
- Excellent Good Poor
- Very Good Fair

19. What type of exercise do you do?

- Strenuous
- Moderate
- Light
- None

20. Indicate if you have any immediate family members with any of the following:

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

21. For each of the conditions listed below, place a check in box if you *presently* have the condition. If you have had the condition in the *past* place a **P** next to box.

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

For Females Only

- Birth control pills
- Hormonal Replacement
- Pregnancy

22. List all prescription medications you are currently taking: _____

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

24. List all surgical procedures you have had: _____

25. What activities do you do at work?

- | | | | |
|----------------------|--|---------------------------------------|--|
| Sit | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| Stand | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| Computer work | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| On the phone | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |

26. What activities do you do outside of work? _____

27. Have you ever been hospitalized?

- No
- Yes

If yes, why _____

28. Have you had significant past trauma?

- No
- Yes

29. Anything else pertinent to your visit today? _____

30. If we find we can help, is there anything that would prevent you from taking care of this? _____

Patient Signature _____ Date _____