

CONFIDENTIAL PATIENT INTAKE FORM

NAME: _____ AGE: _____ DOB: _____ SS# _____

HOME ADDRESS: _____ CITY: _____ ST: _____ ZIP _____

EMPLOYER: _____ OCCUPATION: _____ E-MAIL _____ @ _____

HOME TEL: _____ PAGER/CELL _____ WORK TEL: _____ FAX: _____

EMERGENCY CONTACT: _____ TEL: _____ PHYSICIAN: _____

SINGLE MARRIED DIVORCED WIDOWED SIGNIFICANT OTHER # CHILDREN _____

SPOUSE: _____ DOB: _____ TEL: _____ SS#: _____

EMERGENCY CONTACT: _____ TEL: _____ PHYSICIAN: _____

REFERRED BY: DR. _____ PATIENT: _____ OTHER: _____

HEALTH INSURANCE: NO YES: _____

YOU ARE CURRENTLY EXPERIENCING: BACK PAIN NECK PAIN HEADACHE OTHER _____

DESCRIBE : _____

THIS HAPPENED *WHEN*? _____ *WHERE*? HOME WORK CAR WRECK OTHER _____

THIS HAPPENED *HOW*? _____

HAVE YOU HAD THIS OR SIMILAR HAPPEN BEFORE? _____

WHAT MAKES THE PROBLEM BETTER? _____

WHAT MAKE THE PROBLEM WORSE? SITTING STANDING LYING MOVEMENT REST
 USE WALKING RUNNING WORKING ACTIVITY
 BENDING LIFTING TWISTING OTHER _____

DESCRIBE THE PAIN OR SENSATION: ACHY BURNING DULL NUMB SHARP
 SHOOTING SORE STABBING STIFF TINGLING

DOES THE PAIN RADIATE TO ANOTHER AREA OF THE BODY? NO YES - *WHERE*? _____

HOW FREQUENT IS THE PROBLEM? CONSTANT FREQUENT INTERMITTENT OCCASIONAL ON/OFF
 EVENING ONLY MORNING ONLY WORSE IN THE: AM or PM

WHAT % OF THE DAY DO YOU EXPERIENCE THIS PROBLEM? 0-25% 26-50% 51-75% 76-100%

OTHER DR.S SEEN FOR THIS CONDITION: NO YES: _____ WHEN? _____

PAST CHIROPRACTIC CARE: NO YES DRS NAME: _____ WHEN? _____

CONSENT

I consent to any physical examination, x-ray study, laboratory procedures, chiropractic or adjunctive therapy or clinic service that is ordered under the general and specific instructions of the doctor(s).

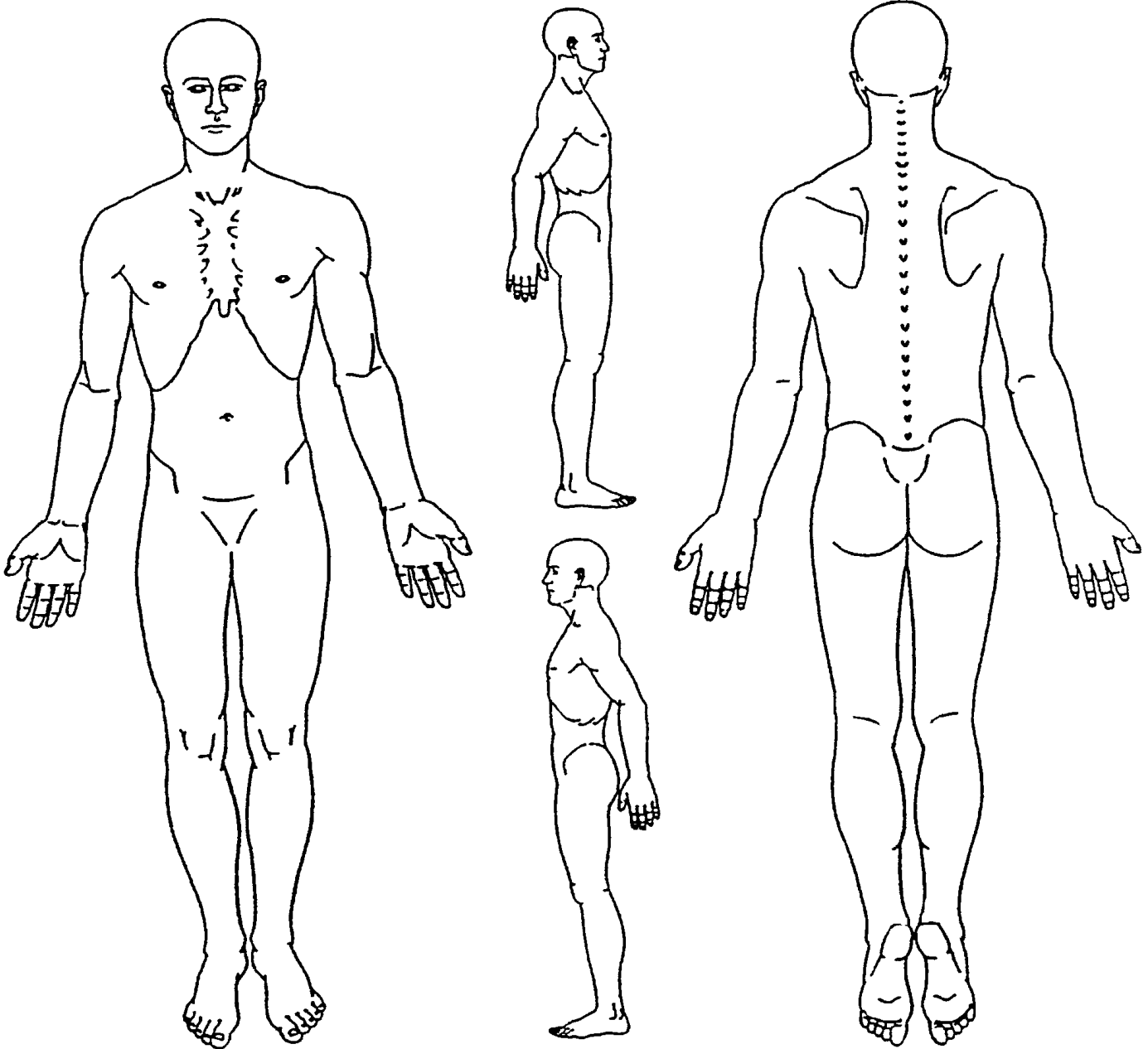
PATIENT SIGNATURE: _____ DATE _____

GUARDIAN SIGNATURE: _____ DATE _____ rev.08.09.07

PAIN DRAWING

On the diagrams below please mark where you are experiencing your symptoms.

X = PAIN / DISCOMFORT
O = NUMBNESS / TINGLING



Patient Signature: _____ Date: _____ rev08.09.07

Check or circle the appropriate response, please leave blank if it does not apply.

Past Medical and/or Family History

(P=patient, M=mom, F=father,

S=Sibling)

- Heart Disease P M F S
- Asthma P M F S
- Cancer P M F S
- Arthritis P M F S
- Headaches P M F S
- Diabetes P M F S
- MVP P M F S
- Emphysema P M F S
- Anemia P M F S
- Fibromyalgia P M F S
- Hernia P M F S
- High BP P M F S
- Low BP P M F S
- Alzheimers P M F S
- Alcoholism P M F S
- Colitis P M F S
- Epilepsy P M F S
- Goiter P M F S
- Gout P M F S
- High Cholesterol P M F S
- Kidney Disease P M F S
- Leukemia P M F S
- Lupus P M F S
- Mental Condition P M F S
- Obesity P M F S
- Rheumatoid Arth. P M F S
- Ulcers P M F S
- Injuries P M F S
- Trauma auto/etc. P M F S
- Other P M F S

Surgical History

- Appendectomy Hemorrhoid
- Gall Bladder Tonsillectomy
- Thyroidectomy Kidney Stone
- Bladder Endoscopy
- Angioplasty Heart Bypass
- Back/Neck Surgery
- Arthroscopic _____
- Joint Replacement _____
- Fracture _____
- Cancer Biopsy _____
- Other _____
- Other _____
- Other _____

Social History

- Caffeine: No Light Heavy
- Tobacco: No Yes
- Packs Per day _____
- Alcohol: No Yes
- _____ per day/week
- No work Part time
- Full Time School
- Retired Disability

Exercise

- Frequently
- Occasionally
- Rarely

Review Of Systems

Please circle if you have had any problems in any of the following:
(P=Past, 1=Mild, 2=Moderate, 3=Severe)

General Health

- P 1 2 3 Fatigue/Tiredness
- P 1 2 3 Fever/Night Sweats
- P 1 2 3 Trouble Sleeping
- P 1 2 3 Skin Irritation/Rash
- P 1 2 3 Bleeding Disorder
- P 1 2 3 Depression
- P 1 2 3 Anxiety/Tension/Stress

EENT

- P 1 2 3 Vision/Eye
- P 1 2 3 Hearing/Ear
- P 1 2 3 Throat/Swallowing
- P 1 2 3 Nasal/Sinus
- P 1 2 3 Headaches/Face Pain

Cardiopulmonary

- P 1 2 3 Breathing
- P 1 2 3 Swelling/Edema
- P 1 2 3 Chest Pain

GI

- P 1 2 3 Stomach/Abdominal
- P 1 2 3 Diarrhea/Constipation
- P 1 2 3 Vomiting/Nausea
- P 1 2 3 Reflux/Indigestion

GU

- P 1 2 3 Urinary Frequency/Urgency
- P 1 2 3 Urinary/Burning/Discoloration
- P 1 2 3 Sexual/Reproductive

Skeletal

- P 1 2 3 Morning Stiffness
- P 1 2 3 Night Pain
- P 1 2 3 Neck Pain
- P 1 2 3 Back Pain
- P 1 2 3 Joint Pain _____

NeuroMuscular

- P 1 2 3 Muscle Pain
- P 1 2 3 Weakness
- P 1 2 3 Numbness/Tingling
- P 1 2 3 Tremors/Shakes
- P 1 2 3 Loss of Consciousness
- P 1 2 3 Passing out

Females

- Pregnant: Yes No I Don=t Know
- Last Menstrual Cycle _____
- Endometriosis Hysterectomy
- Tubaligation C-Section
- Breast Implants Breast Biopsy
- Mastectomy

Males

- Prostate problems

Present Medication

- None List _____
- _____
- _____
- _____

Allergies

- Penicillin Codeine
- Aspirin Sulfa
- Other _____
- Other _____

Section 1 - Pain intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 - Walking

- I have no pain walking.
- I have some pain walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

Section 5 - Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than one hour.
- Pain prevents me from sitting for more than 30 minutes.
- Pain prevents me from sitting for more than 10 minutes.
- I avoid sitting because it increases pain right away.

Section 6 - Standing

- I can stand as long as I want without extra pain.
- I have some pain when standing but it does not increase with time.
- I can't stand for longer than one hour without increasing pain.
- I can't stand for longer than 30 min. without increasing pain.
- I can't stand for longer than 10 min. without increasing pain.
- I avoid standing because it increases the pain right away.

Section 7 - Social Life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interest (dancing, etc.)
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

Section 8 - Traveling

- I have no pain while traveling.
- I get some pain while traveling but none of my usual forms of travel make it any worse.
- I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.

Section 9 - Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed. (less than 1 hour sleepless)
- My sleep is mildly disturbed. (1-2 hours sleepless)
- My sleep is moderately disturbed. (2-3 hours sleepless)
- My sleep is greatly disturbed. (3-5 hours sleepless)
- My sleep is completely disturbed. (5-7 hours sleepless)

Section 10 - Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Please read instructions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. **Please check the ONE ITEM in each section** which most closely applies.

PAIN SEVERITY SCALE: Rate the severity of your pain by checking **one** box on the following scale:

0	1	2	3	4	5	6	7	8	9	10
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No Pain

Excruciating

Pain_{rev.08.09.07}