

## 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 \_\_\_\_\_

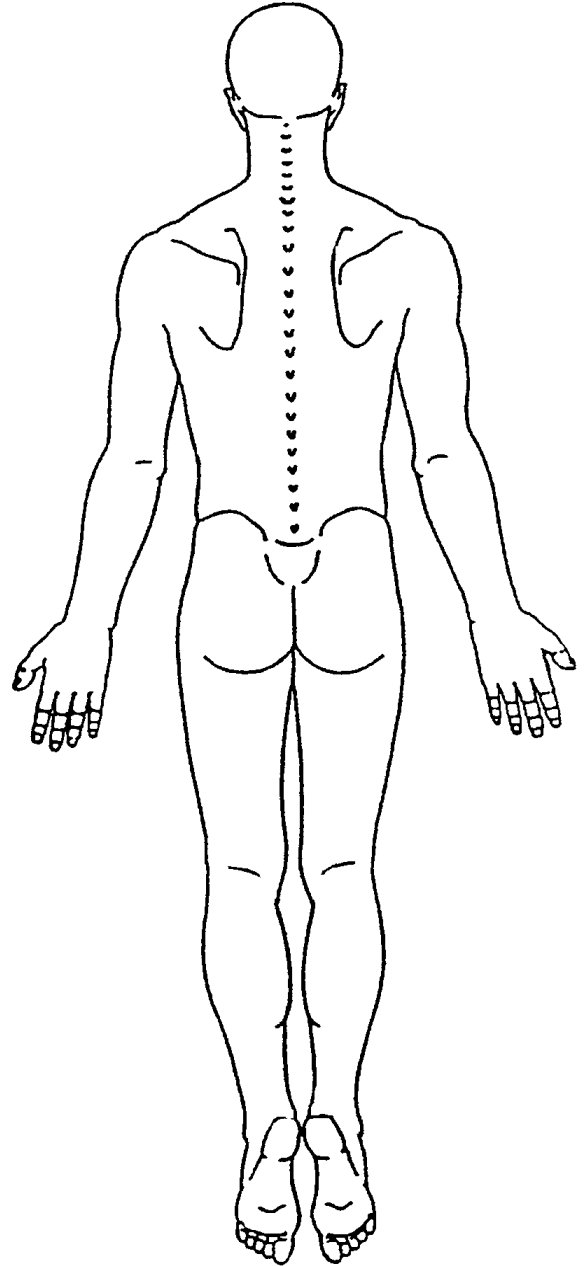
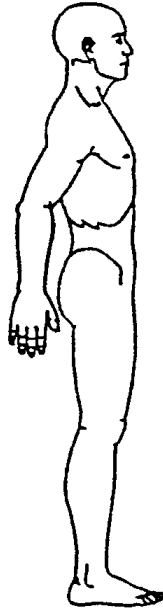
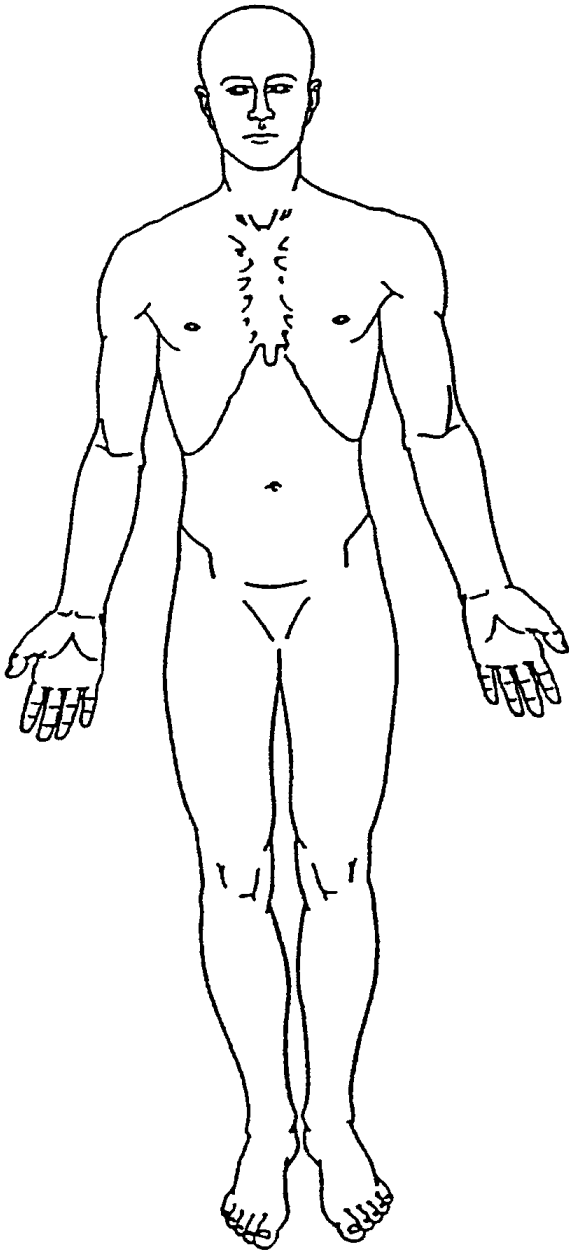
GUARDIAN SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

## 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)

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

**Surgical History**

- |  |  |
|--|--|
| <input type="checkbox"/> Appendectomy            | <input type="checkbox"/> Hemorrhoid    |
| <input type="checkbox"/> Gall Bladder            | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Thyroidectomy           | <input type="checkbox"/> Kidney Stone  |
| <input type="checkbox"/> Bladder                 | <input type="checkbox"/> Endoscopy     |
| <input type="checkbox"/> Angioplasty             | <input type="checkbox"/> Heart Bypass  |
| <input type="checkbox"/> Back/Neck Surgery       |  |
| <input type="checkbox"/> Arthroscopic _____      |  |
| <input type="checkbox"/> Joint Replacement _____ |  |
| <input type="checkbox"/> Fracture _____          |  |
| <input type="checkbox"/> Cancer Biopsy _____     |  |
| <input type="checkbox"/> Other _____             |  |
| <input type="checkbox"/> Other _____             |  |
| <input type="checkbox"/> 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 \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_ rev.08.09.07

**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 to you.

**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 - Reading**

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight neck pain
- I can read as much as I want with moderate neck pain
- I can't read as much as I want because of moderate neck pain
- I can hardly read at all because of severe neck pain
- I cannot read at all

**Section 5 - Headaches**

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently
- I have moderate headaches which come frequently
- I have severe headaches which come frequently.
- I have headaches almost all the time.

**Section 6 - Concentration**

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating
- I have a lot of difficulty in concentrating
- I have great difficulty in concentrating
- I cannot concentrate at all.

**Section 7 - Work**

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

**Section 8 - Driving**

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck. in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all

**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 - Recreation**

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of neck pain.
- I can't do any recreation activities at all.

**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
---	---	---	---	---	---	---	---	---	---	----

No Pain

Excruciating

Pain<sub>rev.08.09.07</sub>