

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).

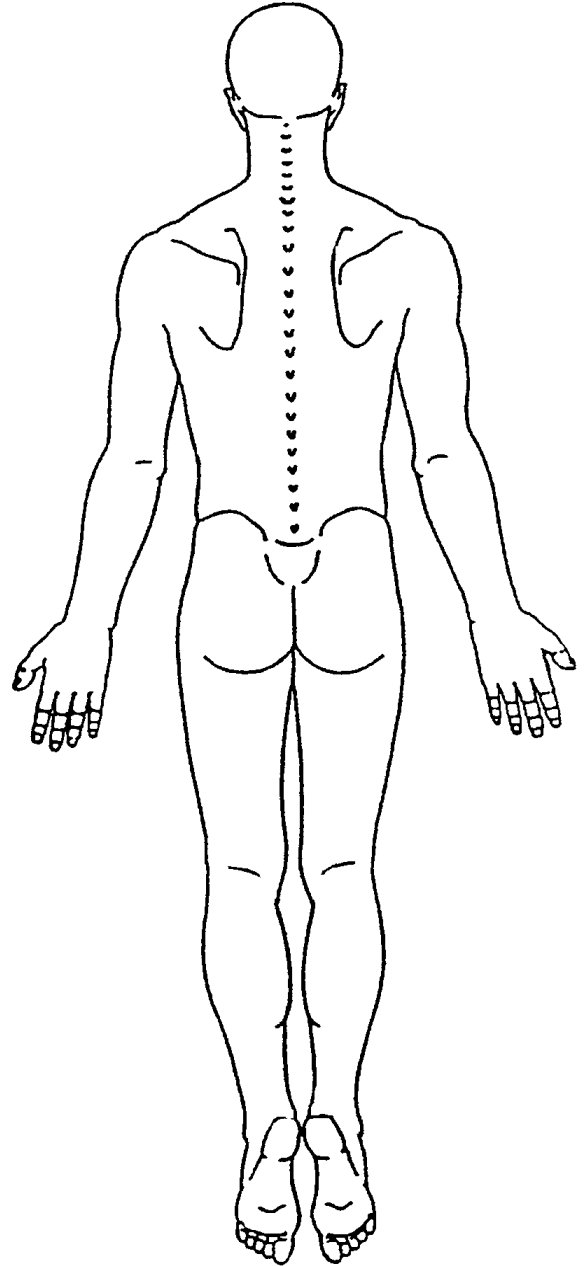
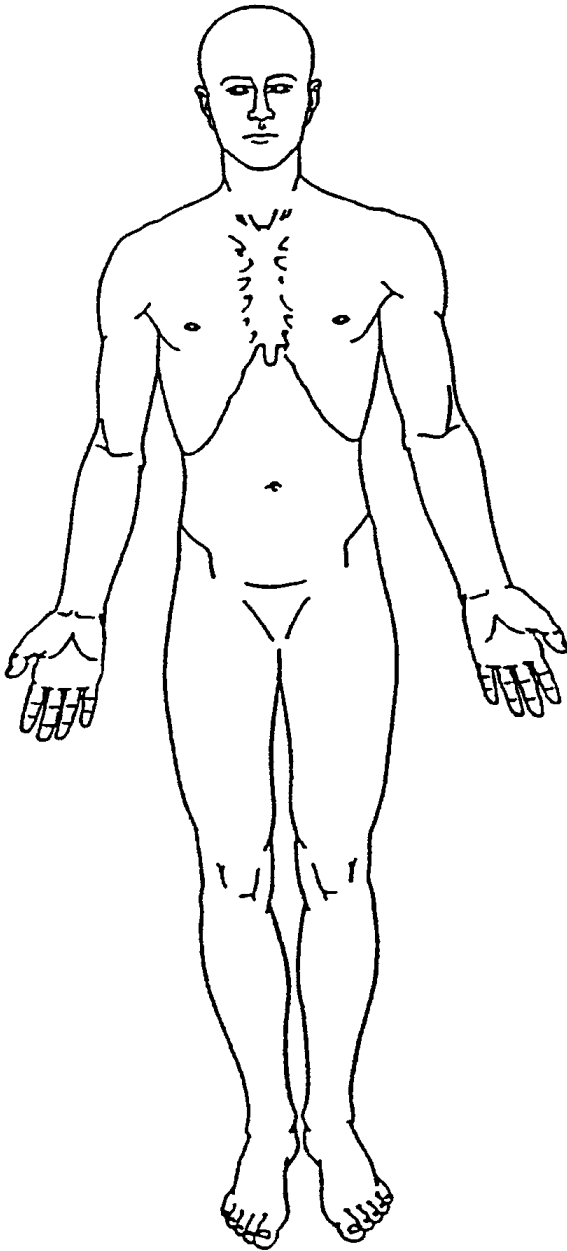
PATIENT SIGNATURE: _____ DATE _____

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: _____

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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 _____

Patient Name: _____ Date: _____

Reviewer: _____ Date: _____ rev.08.09.07