Patient Intake Form

Name _____ □ Male □ Female

Address _____ City/State _____ Zip_____

SSN _____ Date of Birth _____ Age _____

Phone number(s): Home _____ Work _____ Cell _____

Email address: _____

Marital Status □ Married □ Divorced □ Single □ Widowed

Race: African American Asian Caucasian Hispanic Other Ethnicity: Hispanic Non-Hispanic

Occupation _____ Employer _____

Emergency Contact _____ Relation _____

Contact number(s) _____

How were you referred to us or hear about us?_____

What is your major complaint:_____

_____

Please mark the involved area(s) using the appropriate symbols:

Numbness --- Tingling /// Stabbing ### Burning ^^^ Aching xxxx

Physician/Staff Use Only

BP_____

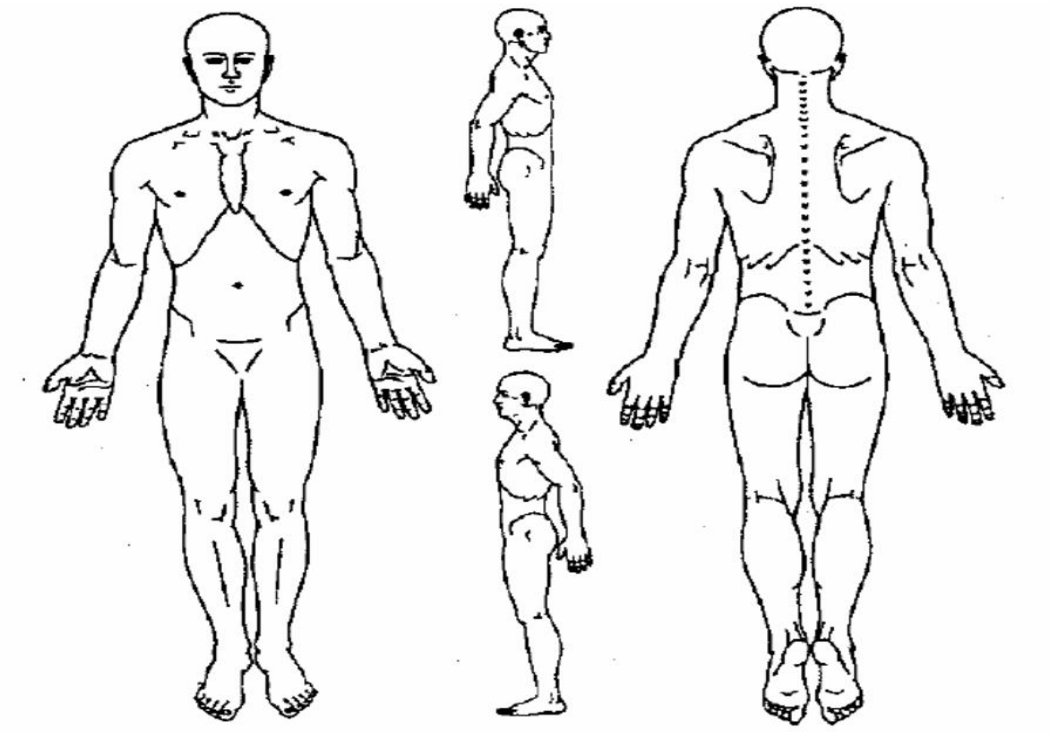
Temp_____

Pulse_____

Resp_____

HT_____

WT_____



Onset: When were you first aware of this problem? _____
_____

Mechanism: What do you think caused this condition? _____
_____

Have your symptoms been: □ Getting better □ Getting worse □ Staying the same

Provocative: Do any positions, movements or activities make your symptoms worse?

Sitting Standing Bending Lifting Walking Driving

_____
_____

Is this condition interfering with your: □ Work □ Sleep □ Daily Routine
□ Other:_____

Palliative: What makes your symptoms better? Ice Heat Rest Medication Activity Avoidance

_____
_____

Quality (describe the symptoms you are having)

Dull Sharp Sore Achy Tight Stiff Burning Numbness Tingling Shooting Stabbing

_____
_____
_____

Radiating symptoms (do any of your symptoms radiate into the arms, legs, hands or feet?):

_____
_____

Severity (rate your pain on the following scale):

No pain			Mild Pain			Moderate Pain			Severe Pain			Worst Possible
0	1	2	3	4	5	6	7	8	9	10		

Timing: Is your pain better or worse during certain times of day or night?_____
_____

Frequency (please describe the frequency of your symptoms…Examples: constant, comes and goes, occasional, etc.): _____
_____

Have you ever had this problem or similar problem before? □ Yes □ No
If yes, explain:_____

Patient Name:_____ ID: _____

Have you previously received treatment for this condition? □ Yes □ No
If yes, by: □ Physician □ Chiropractor □Physical Therapist

What treatment and/or recommendations did you receive?_____
_____
_____

Who is your primary care physician?_____
City & State:_____

Review of systems: Do you **currently** have any of these symptoms/conditions? Select **all** that apply.

CV: □ chest pain □ palpitations □ shortness of breath □ cold arms/legs □ swelling feet/legs
Musc/Skel: □ arthritis □ fractures in past □ weak extremities
Neuro: □ numbness in hands/feet □ tingling in hands/feet

PAST MEDICAL HISTORY: select all that apply to you and your family.

Disease	**You**	**Family**	**Disease**	**You**	**Family**
Kidney Disease			Seizures		
Diabetes			Gout		
High Blood Pressure			Asthma		
Heart Attack			Osteoporosis		
Stroke			Emphysema		
Coronary artery disease			Heart Failure		
Cancer:_____			Rheumatoid Arthritis		
Peripheral artery disease			Atrial Fibrillation		
Blood clot			Osteoarthritis		
Pacemaker			HIV/AIDS		
Stomach ulcers			Hepatitis		

Surgical History: select all that apply to**YOU**.

Surgery	**Date**	**Surgery**	**Date**
Tonsillectomy		Fracture repair	
Appendectomy		Hip replacement	
Hysterectomy		Knee replacement	
Gallbladder		Knee scope	
Heart bypass		Shoulder scope	
Heart stents		Spinal Surgery	
Heart valve		Other:	
Hernia repair		Other:	
C-section		Other:	

Medication List (please list all of your current medications, including over-the-counter medicines, vitamins, herbal supplements)

_____
_____
_____
_____
_____

Drug Allergies: □ None □ Penicillin □ Sulfa □ Other:_____

Are you currently pregnant? □ Yes □ No
Are you currently taking birth control? □ Yes □ No

Social History:
Do you smoke? □ Yes □ No If yes, how much? _____ packs / day
Do you drink alcohol? □ Yes □ No If yes, how often? _____ times / week

Patient Signature:_____ Date:_____

Physician/Staff use only:

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Patient Name:_____ ID: _____