# PATIENT INTAKE FORM

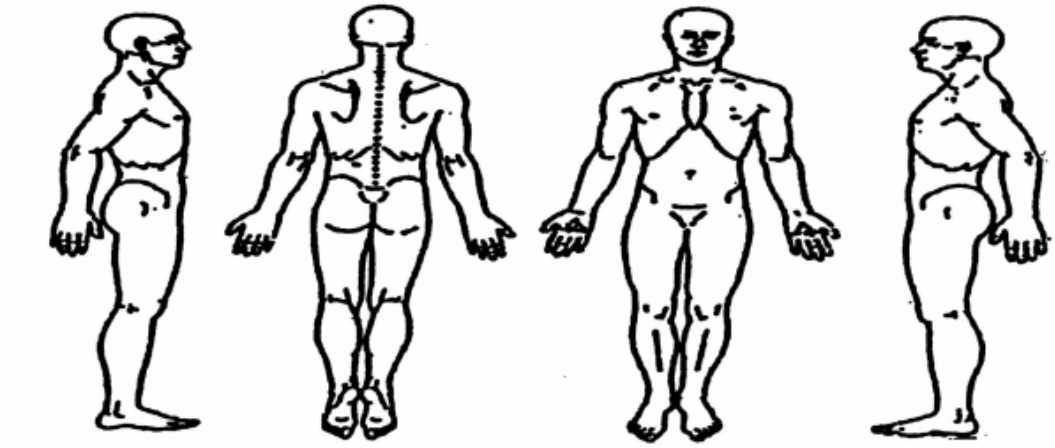
Patient Name: _____ Date: _____
Referred By: _____ Phone: h_____
Street Address: _____ c_____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____
Social Security #: _____-_____-_____ Marital Status: _____ Number of Children : _____
E-mail: _____
Would you like health and promotional updates via e-mail? yes or no
Is there a possibility that you may be pregnant today? yes or no

## Insurance Information:

Name of Insurance Company: _____
Name of the Insured: _____Date of Birth: _____ Employer: _____
ID# _____ Group # _____ Effective Date: _____

**1. Is today's problem caused by:** □ Auto Accident □ 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 □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

**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?**

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

**7. How much has the problem interfered with your work?**

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

**8. How much has the problem interfered with your social activities?**

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

**9. Do you consider this problem to be severe?**

□ Yes □ Yes, at times □ No

**10. Who else have you seen for your problem?**

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

**11. How long have you had this problem? _____**

**12. How do you think your problem began?_____**

**13. What aggravates your problem?_____**

**14. What concerns you the most about your problem; what does it prevent you from doing?**

_____

**15. Occupation _____**

**16. How would you rate your overall Health?**

□ Excellent □ Very Good □ Good □ Fair □ Poor

**17. What type of exercise do you do?**

□ Strenuous □ Moderate □ Light □ None

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

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

**19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

| Past | Present | Past | Present | Past | Present |
|---|---|---|---|---|---|
| □ | □ Headaches | □ | □ High Blood Pressure | □ | □ Diabetes |
| □ | □ Neck Pain | □ | □ Heart Attack | □ | □ Excessive Thirst |
| □ | □ Upper Back Pain | □ | □ Chest Pains | □ | □ Frequent Urination |
| □ | □ Mid Back Pain | □ | □ Stroke | □ | □ Smoking/Tobacco Use |
| □ | □ Low Back Pain | □ | □ Angina | □ | □ Drug/Alcohol Dependance |
| □ | □ Shoulder Pain | □ | □ Kidney Stones | □ | □ Allergies |
| □ | □ Elbow/Upper Arm Pain | □ | □ Kidney Disorders | □ | □ Depression |
| □ | □ Wrist Pain | □ | □ Bladder Infection | □ | □ Systemic Lupus |
| □ | □ Hand Pain | □ | □ Painful Urination | □ | □ Epilepsy |
| □ | □ Hip Pain | □ | □ Loss of Bladder Control | □ | □ Dermatitis/Eczema/Rash |
| □ | □ Upper Leg Pain | □ | □ Prostate Problems | □ | □ HIV/AIDS |
| □ | □ Knee Pain | □ | □ Abnormal Weight Gain/Loss | | |
| □ | □ Ankle/Foot Pain | □ | □ Loss of Appetite | **For Females Only** | |
| □ | □ Jaw Pain | □ | □ Abdominal Pain | □ | □ Birth Control Pills |
| □ | □ Joint Pain/Stiffness | □ | □ Ulcer | □ | □ Hormonal Replacement |
| □ | □ Arthritis | □ | □ Hepatitis | □ | □ Pregnancy |
| □ | □ Rheumatoid Arthritis | □ | □ Liver/Gall Bladder Disorder | | |
| □ | □ Cancer | □ | □ General Fatigue | | |
| □ | □ Tumor | □ | □ Muscular Incoordination | | |
| □ | □ Asthma | □ | □ Visual Disturbances | | |
| □ | □ Chronic Sinusitis | □ | □ Dizziness | | |

**22. List all surgical procedures you have had:**

_____

**23. What activities do you do at work?**

□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

**24. What activities do you do outside of work?_____**

**25. Have you ever been hospitalized?** □ No □ Yes if yes, why

_____

**26. Have you had significant past trauma?** □ No □ Yes

**Patient Signature_____ Date:_____**

**OFFICE USE ONLY**

Blood Pressure: _____/_____ Height: _____ Weight: _____

**Smoking Status: (Please circle)**

| | | | |
|---|---|---|---|
| Smokes every day | Smokes some days | Former smoker | Never smoker |

## Prescribed Medicines

Check here if not taking any medications: ☐

| **Medication** i.e. Lipitor | **# of MD refills issued:** | **Quantity of Pills:** | **Strength** i.e. 10 mg | **Dose Form** i.e. Capsule | **MD's Instruction:** i.e. 1 per day |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Are you allergic to any medicines? Please list each drug on a new line:**

Check here if you do not have any medical allergies: ☐

| **Name of Drug:** i.e.penicilliin | **Symptom:** i.e. headache |
|---|---|
| | |
| | |
| | |

**Have you been diagnosed with either of the following: (Please circle)**

| | |
|---|---|
| Asthma | Diabetes |

### Microsoft Health Vault Opt Out

I understand that my chiropractor, has the ability to provide me with electronic health records, via Microsoft Health Vault. I have chosen not to participate in this program.

_____ _____

Patient name (printed) Date

_____

Patient Signature