

PATIENT INTAKE FORM

Patient Name: _____

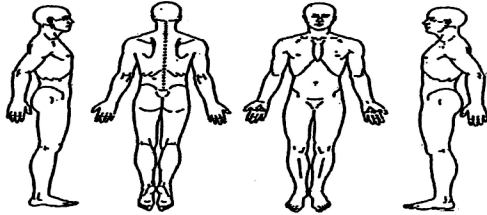
Date: _____



FAMILY FIRST CHIROPRACTIC

For a healthier tomorrow.

1. Indicate on the drawings below where you have pain/symptoms



2. 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)

3. 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: _____

4. How are your symptoms changing with time? Getting Worse Staying the Same Getting Better

5. 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)

6. How much has the problem interfered with your work?

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

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

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

8. Who else have you seen for your problem?

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

9. How long have you had this problem? _____

10. How do you think your problem began? _____

11. Do you consider this problem to be severe? Yes Yes, at times No

12. What aggravates your problem?

- Always there Bending Riding a bike Breathing deeply
Climbing Stairs Coughing Driving Going down Stairs
Playing golf Painting Picks up child Running
Sitting Sleeping Sneezing Standing
When under stress Using the phone Playing tennis Throwing a ball
Turns over in bed Traveling Walking At work
Working at a computer Exercising Other _____

13. What alleviates the problem?

- Getting Adjusted Uses Analgesic cream Bends forward Exercises
Uses Heat Uses Ice Lies face down Lies on side
Lies on back Gets massage Uses muscle relaxors Takes aspirin
Does pilates Rests Stands Stretches
Swimming Warm Bath Walking Uses Orthotics
Doing Yoga Prescription medication Other _____



14. What concerns you the most about your problem?

- Could be serious
- It isn't going away
- Its affecting leisure activities
- Its getting worse
- Its affecting work
- Its affecting golf
- Its affecting relationships
- Its affecting mental outlook
- Other: _____

15. What is your: Height _____ Weight _____ Age _____

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

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

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

25. Have you ever been hospitalized? No Yes
If yes, please explain _____

26. Have you had significant past trauma? No Yes
If yes, please explain _____

27. Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____