Patient Intake Form

Patient Name _____

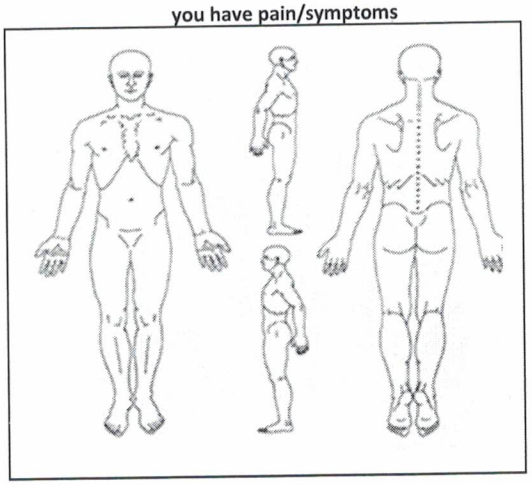
Reason for Visit _____

When did you first notice your symptoms? _____

How do you think your symptoms began? _____

Symptoms: _____

Indicate on the drawings where you have pain/symptoms



How often do you experience your symptoms?

◯Constantly (76-100%) of the time ◯Frequently (51-75% of the time)

◯Occasionally (26-50% of the time ◯Infrequently (1-25% of the time

How are your symptoms changing with time?

◯Getting worse ◯Staying the same ◯Getting Better

Type of pain ◯Sharp ◯Dull ◯Throbbing ◯Numbness

◯Burning ◯Tingling ◯Cramps ◯Stiffness

◯Achiness ◯Shooting ◯Swelling ◯Other: _____

Rate the severity of your pain (1=mild pain/discomfort, to 10=severe pain/discomfort) 1 2 3 4 5 6 7 8 9 10

What aggravates your condition? _____

What makes your condition better? _____

What treatment have you received for your condition?

◯Chiropractic ◯Medication ◯Physical therapy ◯Massage ◯Surgery ◯None ◯Other_____

How much has your condition interfered with your work and social activities?

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

Do you consider your condition to be severe? ◯Yes ◯No

What concerns you most about your condition? _____

What does it prevent you from doing? _____

Family history: ◯Rheumatoid Arthritis ◯Heart problems ◯Diabetes ◯Cancer ◯Lupus ◯ALS

Health history: Check ONLY those conditions which are applicable

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
◯	◯	Headaches	◯	◯	ALS	◯	◯	Herniated disc	◯	◯	Smoking
◯	◯	Neck pain	◯	◯	Arthritis	◯	◯	High cholesterol	◯	◯	Stroke
◯	◯	Upper back pain	◯	◯	Asthma	◯	◯	Kidney disease/stones	◯	◯	Thyroid problem
◯	◯	Mid back pain	◯	◯	Blood disorder	◯	◯	Liver disease	◯	◯	Tuberculosis
◯	◯	Low back pain	◯	◯	Breast lump	◯	◯	Measles	◯	◯	Tumor/growth
◯	◯	Shoulder pain	◯	◯	Cancer	◯	◯	Migraines	◯	◯	Ulcers
◯	◯	Elbow/arm pain	◯	◯	Depression	◯	◯	Miscarriage	◯	◯	Visual disturbances
◯	◯	Wrist pain	◯	◯	Diabetes	◯	◯	Mononucleosis	◯	◯	Whooping cough
◯	◯	Hand pain	◯	◯	Dizziness	◯	◯	Muscular incoordination	◯	◯	Other: _____
◯	◯	Hip pain	◯	◯	Drug/Alcohol dependency	◯	◯	Multiple sclerosis			_____
◯	◯	Upper leg pain	◯	◯	Emphysema	◯	◯	Mumps			
◯	◯	Knee pain	◯	◯	Epilepsy	◯	◯	Osteoporosis			
◯	◯	Ankle/foot pain	◯	◯	Fractures	◯	◯	Pacemaker			
◯	◯	Jaw pain	◯	◯	Glaucoma	◯	◯	Parkinson' disease			
◯	◯	Joint pain/stiffness	◯	◯	General fatigue	◯	◯	Pinched nerve			
◯	◯	Abnormal weight gain/loss	◯	◯	Gout	◯	◯	Prostate problems			
◯	◯	Eating disorders	◯	◯	Heart disease	◯	◯	Psychiatric care			
◯	◯	Allergy shots	◯	◯	Hepatitis	◯	◯	Prosthesis			
◯	◯	AIDS/HIV	◯	◯	Hernia	◯	◯	Rheumatoid arthritis/RA variants			

Women: Are you pregnant? ◯ yes ◯ no Nursing? ◯ yes ◯ no Taking birth control? ◯yes ◯no

List any surgeries/hospitalizations you have had and dates they occurred _____

_____

List any traumas/motor vehicle accidents/fractures you have had and dates which they occurred _____

_____