PATIENT INTAKE FORM

NAME: _____ TODAY'S DATE: _____
FIRST MIDDLE LAST

AGE: _____ RACE: _____ D.O.B.: _____

1. **NAME OF DOCTOR (PERSON) THAT REFERRED YOU TO OUR PRACTICE:** _____
2. **NAME OF YOUR PRIMARY CARE DOCTOR:** _____
3. **WHY ARE YOU SEEING THE DOCTOR TODAY? (WHERE DO YOU HURT?)** _____
   _____
4. **ONSET OF SYMTOMS: HOW LONG HAVE YOU HAD THIS PROBLEM?** _____
5. **WHAT CAUSED YOUR PROBLEM?** ◊ INJURY ◊ MOTOR VEHICLE ACCIDENT ◊ WORK ACCIDENT ◊ UNKNOWN
   EXPLAIN: _____
6. **NURSE'S HISTORY:** _____
   _____
   _____
   _____
   _____
   _____
7. **(A) HAVE YOU EVER BEEN TREATED FOR THE SAME SYMPTOMS BEFORE THIS STARTED?** ◊ **Y** ◊ **N**
   IF YES, WHEN? _____ DIAGNOSIS: _____
   (B) DID YOU FULLY RECOVER? ◊ **Y** ◊ **N** IF YES, WHEN? _____
8. **ARE YOU PRESENTLY BEING TREATED BY A DOCTOR FOR YOU INJURIES?** ◊ **Y** ◊ **N**
   IF YES, NAME OF DOCTOR: _____ DATE LAST SEEN: _____
9. **CHECK ALL THAT APPLY TO YOUR SYMPTOMS:**

PAIN QUALITY:	**INCREASE PAIN:**	**DECREASE PAIN:**		**ASSOCIATED SYMPTOMS:**
◊ sharp	◊ sitting	◊ sitting	◊weakness	◊ insomnia
◊ aching	◊ lying down	◊ lying down	◊ numbness	◊ pain wakes at night
◊ burning	◊ walking	◊ walking	◊ tingling	◊ sexual dysfunction
◊ shooting	◊ bending	◊ bending	◊ fever	◊ other _____
◊ constant	◊ weather	◊ weather	◊ weight loss	_____
◊ intermittent	◊ coughing/sneezing		◊ bowel/bladder problems	_____

10. **PREVIOUS TREATMENTS FOR PAIN:**

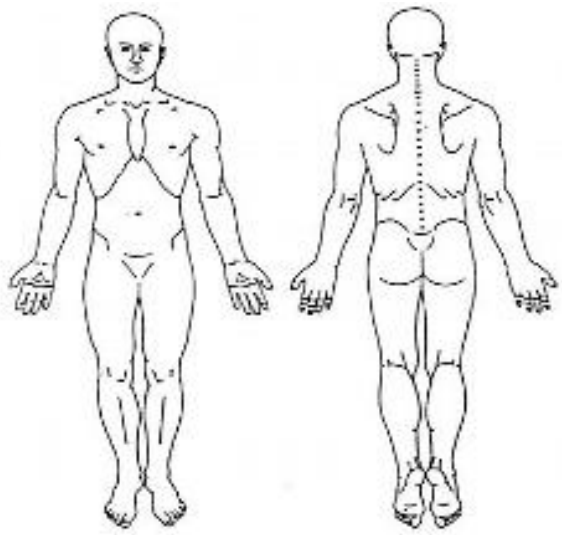
	TREATMENT	**HELPFUL?**	**CURRENT/ONGOING**	**COMMENTS**
Ten Unit?	◊ Y ◊ N	◊ Y ◊ N	◊ Y ◊ N	_____
Physical/Occupational Therapy?	◊ Y ◊ N	◊ Y ◊ N	◊ Y ◊ N	_____
Psychological Evaluation?	◊ Y ◊ N	◊ Y ◊ N	◊ Y ◊ N	WHO: _____
Chiropractic Treatment?	◊ Y ◊ N	◊ Y ◊ N	◊ Y ◊ N	WHO: _____
Nerve Blocks?	◊ Y ◊ N	◊ Y ◊ N	◊ Y ◊ N	WHO: _____
Surgeries?	◊ Y ◊ N	◊ Y ◊ N	Type _____	

11. DIAGNOSTIC INFORMATION:

Radiologic Studies			PART OF BODY	DATE/WHEN	WHERE	RESULTS
X-rays	◊ Y	◊ N	_____	_____	_____	_____
MRI	◊ Y	◊ N	_____	_____	_____	_____
CT Scan	◊ Y	◊ N	_____	_____	_____	_____
EMG (Nerve Study)	◊ Y	◊ N	_____	_____	_____	_____
Bone Scan	◊ Y	◊ N	_____	_____	_____	_____
Myelogram	◊ Y	◊ N	_____	_____	_____	_____
Other	◊ Y	◊ N	_____	_____	_____	_____

12. PAIN DIAGRAM

MARK AS FOLLOWS: A-ACHE B-BURNING N-NUMBNESS P-PINS & NEEDLES
S-STABBING O-OTHER (Describe):



13. PAIN SCALE (MARK WITH AN X ALONG THE BAR TO INDICATE DEGREE)

HOW DO YOU RATE YOUR PAIN NOW? _____

0 None — 5 Moderate — 10 Unbearable

14. MEDICATIONS: ◊ NONE ◊ I PRESENTLY TAKE THE FOLLOWING:

NAME OF MEDICATION	AMOUNT PER DAY	REASON	LAST DOSE TAKEN

15. ALLERGIES:

IVP Dye:	◊ Y	◊ N	Shellfish:	◊ Y	◊ N	Morphine:	◊ Y	◊ N	Aspirin:	◊ Y	◊ N
Steriods:	◊ Y	◊ N	Novocaine:	◊ Y	◊ N	Valium:	◊ Y	◊ N	Other:	◊ Y	◊ N

WHAT TYPE OF REACTION? _____

_____

16. PAST MEDICAL HISTORY:

DO YOU HAVE ANY OF THE FOLLOWING CONDITION?

CNS

◊ Y ◊ N Cerebral Aneurysm
◊ Y ◊ N Stroke
◊ Y ◊ N Brain Tumor
◊ Y ◊ N Seizure Disorder
◊ Y ◊ N Neuropathy

GASTROINTESTINAL

◊ Y ◊ N Hiatal Hernia
◊ Y ◊ N Ulcer
Other: _____

CARDIOVASCULAR

◊ Y ◊ N Hypertension
◊ Y ◊ N Valve Disease
◊ Y ◊ N Heart Attack
Date _____
◊ Y ◊ N Irregular Heartbeat
◊ Y ◊ N Pacemaker

GENITOURINARY

◊ Y ◊ N Kidney Disease
◊ Y ◊ N Are you Pregnant?

RESPIRATORY

◊ Y ◊ N Asthma
◊ Y ◊ N Emphysema
◊ Y ◊ N Bronchitis

PSYCHIATRIC

◊ Y ◊ N Depression
◊ Y ◊ N Anxiety

BONE/MUSCLE

◊ Y ◊ N Arthritis
◊ Y ◊ N Fibromyalgia
Other: _____

METABOLIC

◊ Y ◊ N Liver Disease
◊ Y ◊ N Diabetes/Type ____
◊ Y ◊ N Thyroid
◊ Y ◊ N Bleeding Disorder
Type: _____
◊ Y ◊ N Overweight

INFECTIOUS

◊ Y ◊ N Hepatitis-Type _____
◊ Y ◊ N AIDS
◊ Y ◊ N Cancer
Type _____
Treatment _____

17. REVIEW OF SYSTEMS

CONSTITUTIONAL:

◊ Y ◊ N Fever ◊ Y ◊ N Weight Loss ◊ Y ◊ N Insomnia

MUSCULOSKELETAL:

◊ Y ◊ N Joint Pain ◊ Y ◊ N Joint Swelling

ENT:

◊ Y ◊ N Sinus Headaches

OPTHAMOLOGY:

◊ Y ◊ N Loss of vision ◊ Y ◊ N Blurring of Vision

RESPIRATORY:

◊ Y ◊ N Shortness of Breath ◊ Y ◊ N Cough

CARDIOLOGY:

◊ Y ◊ N Chest Pain ◊ Y ◊ N Congestive Heart Failure ◊ Y ◊ N Leg Swelling

GASTROGENTEROLOGY:

◊ Y ◊ N Heartburn ◊ Y ◊ N Vomiting

NEUROLOGY:

◊ Y ◊ N Headache ◊ Y ◊ N Dizziness ◊ Y ◊ N Seizures

UROLOGY:

◊ Y ◊ N Frequent Urination ◊ Y ◊ N Recurrent UTI

ENDOCRINOLOGY:

◊ Y ◊ N Diabetesh ◊ Y ◊ N Osteoporosis

PSYCHOLOGY:

◊ Y ◊ N Depression ◊ Y ◊ N Sleep disturbances ◊ Y ◊ N High Stress Level

18. SURGICAL HISTORY:

SURGERIES: LIST TYPE & DATE

_____
_____
_____
_____
_____

19. FAMILY HISTORY

HAVE ANY OF YOUR FAMILY HAD THE FOLLOWING:

◊ Y ◊ N Cancer. If Yes, who _____ ◊ Y ◊ N Alcoholism. If Yes, who _____

◊ Y ◊ N Diabetes. If Yes, who _____ ◊ Y ◊ N Drug Abuse. If Yes, who _____

◊ Y ◊ N Heart Disease. If Yes, who _____ ◊ Y ◊ N Suicide. If Yes, who _____

◊ Y ◊ N Psychiatric Disorders. If Yes, who _____ What type _____

20. SOCIAL HISTORY

MARITAL STATUS: ◊ MARRIED ◊ SINGLE ◊ WIDOWED ◊ DIVORCED

CHILDREN: ◊ Y ◊ N HOW MANY? _____

EDUCATION: (Circle highest level attended)

GRADE SCHOOL JUNIOR HIGH SCHOOL 7 8 9 HIGH SCHOOL 10 11 12

COLLEGE 1 2 3 4 GRADUATE SCHOOL

HABITS:

SMOKING: ◊ NONE PACKS PER DAY: _____ HOW MANY YEARS? _____

ALCOHOL: ◊ NEVER ◊ SOCIAL ◊ LIGHT ◊ MODERATE ◊ HEAVY

DRUGS: ◊ NEVER ◊ OCCASIONALLY ◊ FREQUENTLY WHAT KIND? _____

INTRAVENIOUS DRUG USE? ◊ Y ◊ N

21. EMPLOYMENT: (IF INJURY WORK RELATED, COMPLETE WORK ACCIDENT SECTION)

OCCUPATION AT TIME OF INJURY (ONSET): _____ ◊ UNEMPLOYED ◊ RETIRED

CURRENT OCCUPATION: _____ ◊ UNEMPLOYED ◊ RETIRED

TYPE OF WORK: ◊ OFFICE/CLERICAL ◊ LIGHT LABOR ◊ MODERATE LABOR ◊ HEAVY LABOR

IF UNEMPLOYED, ARE YOU RECEIVING ANY OF THE FOLLOWING:

◊ DISABILITY INCOME ◊ WORKMAN'S COMP ◊ RETIREMENT

WHEN DID YOU LAST WORK? _____

WHAT TYPE OF WORK DO/DID YOU DO? _____

NUMBER OF HOURS WORKED PER WEEK? _____

IF ON DISABILITY, WHO PUT YOU ON IT? _____

HAVE YOU EVER BEEN PUT ON WORK RESTRICTIONS? ◊ Y ◊ N

IF YES, WHAT ARE THEY? _____

22. DOCTOR'S NOTES: _____

_____

_____

_____

_____

ALL OF THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____