

# PATIENT INFORMATION

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Social Security # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_ E-mail \_\_\_\_\_

Employer's Name \_\_\_\_\_ Position \_\_\_\_\_ Address \_\_\_\_\_

Marital status – *circle one* [ S M W D ] Are You Insured? [ Y N ] Ins. Company \_\_\_\_\_

Spouse's name \_\_\_\_\_ Are you Pregnant? [ Y N ] Number of children \_\_\_\_\_

Referred by \_\_\_\_\_

**Have you had chiropractic care before?** \_\_\_\_\_ **When?** \_\_\_\_\_

**What is your current complaint?** \_\_\_\_\_

**Is this condition due to:**

- Auto accident     Work injury
- Other accident     Illness
- Unknown cause

**Date symptoms appeared** \_\_\_\_\_

**Check any activities which aggravate your condition:**

- Standing     Lying
- Bending     Coughing
- Twisting     Walking
- Sitting     Lifting

**List all prescription drugs you now take:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are symptoms:**

- Improving
- About the same
- Getting worse
- Intermittent [come and go]

**Other doctors seen for other problems:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List all non-prescription drugs you now take:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you had these symptoms Before?**

- No
- Yes When? \_\_\_\_\_

**List all previous accidents:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Check here if you**

- smoke
- don't exercise regularly

**Who is your general practitioner? Dr.** \_\_\_\_\_

**List all surgical operations:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Check here if you have a family history of :**

- arthritis
- cardiovascular disease
- diabetes
- cancer

Would you like us to send a report to your general practitioner?

- Yes     No

*I understand and agree that medical insurance policies are an arrangement between my insurance company and myself - not my insurance company and this office. I authorize this office to release any medical information and complete any usual and customary reports and forms at no charge, to assist in collecting from my insurance company. However, I understand that I am ultimately responsible for payment in full and agree to pay a \$10 per month billing charge and a 1.5% monthly interest charge for all unpaid balances, which become 30 days past due. If necessary, I also agree to take full responsibility for all third party costs, including collection agencies, reasonable attorney fees and/or court costs incurred in attempting to collect this debt. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.*

*I have read this financial policy. I understand and agree to all the terms of this policy.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
[Parent's signature if minor]

**Please check the type of care desired so that we may be guided by your wishes when possible:**

- Temporary relief     Control of immediate problem     Total healthcare     I prefer the Dr. to select the type of care he feels is best for me

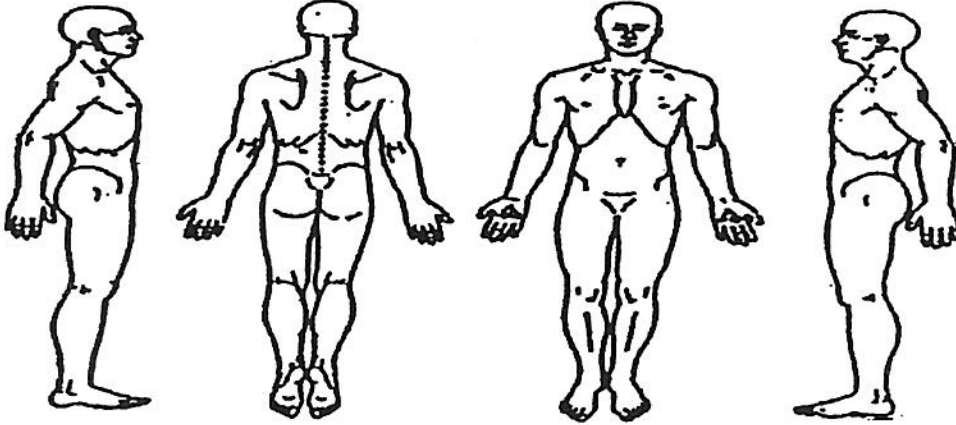
1. What was the date of the injury? \_\_\_\_\_
2. What time did the injury occur? \_\_\_\_\_
3. What is the name of your employer? \_\_\_\_\_
4. What is the street address of your employer? \_\_\_\_\_
5. What is the City, State, and Zip of your employer? \_\_\_\_\_
6. What is the name of your attorney? \_\_\_\_\_
7. What is the street address of your employer? \_\_\_\_\_
8. What is the City, State, and Zip of your attorney? \_\_\_\_\_
9. Please describe your incident in a few sentences: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Did you report the incident to your supervisor? \_\_\_\_\_
11. What is your Supervisor's name? \_\_\_\_\_
12. Did your employer send you to a doctor? If yes, please provide the doctor's name  
\_\_\_\_\_
13. Did you go to a doctor on your own? If yes, please provide the doctor's name  
\_\_\_\_\_
14. Are there any other problems that affect your employment?  
\_\_\_\_\_
15. Does your job cause you to favor one side of your body? \_\_\_\_\_
16. Before the injury, were you capable of performing equal work with others your age?  
\_\_\_\_\_
18. Have you injured this area before? -yes                      - no

# PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ 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. Who else have you seen for your problem?

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

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes  Yes, at times  No

13. What aggravates your problem?

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

15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_

16. How would you rate your overall Health?  
 Excellent     Very Good     Good     Fair     Poor

17. What type of exercise do you do?  
 Stenuous     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"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<b>For Females Only</b>
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<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 Incoordination		
<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		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

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?  
 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

27. Anything else pertinent to your visit today? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_