

## PATIENT INTAKE FORM

NAME: \_\_\_\_\_  
FIRST MIDDLE LAST

TODAY'S DATE: \_\_\_\_\_

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 SYMPTOMS: 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:
<input type="checkbox"/> sharp	<input type="checkbox"/> sitting	<input type="checkbox"/> sitting	<input type="checkbox"/> weakness
<input type="checkbox"/> aching	<input type="checkbox"/> lying down	<input type="checkbox"/> lying down	<input type="checkbox"/> numbness
<input type="checkbox"/> burning	<input type="checkbox"/> walking	<input type="checkbox"/> walking	<input type="checkbox"/> tingling
<input type="checkbox"/> shooting	<input type="checkbox"/> bending	<input type="checkbox"/> bending	<input type="checkbox"/> fever
<input type="checkbox"/> constant	<input type="checkbox"/> weather	<input type="checkbox"/> weather	<input type="checkbox"/> weight loss
<input type="checkbox"/> intermittent	<input type="checkbox"/> coughing/sneezing	<input type="checkbox"/> bowel/bladder problems	<input type="checkbox"/> insomnia
			<input type="checkbox"/> pain wakes at night
			<input type="checkbox"/> sexual dysfunction
			<input type="checkbox"/> other _____

10. PREVIOUS TREATMENTS FOR PAIN:

	TREATMENT	HELPFUL?	CURRENT/ONGOING	COMMENTS
Ten Unit?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Physical/Occupational Therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Psychological Evaluation?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	WHO: _____
Chiropractic Treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	WHO: _____
Nerve Blocks?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	WHO: _____
Surgeries?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Type _____	_____



**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

**OPHTHAMOLOGY:**

- 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

**GASTROENTEROLOGY:**

- 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

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**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: \_\_\_\_\_