PATIENT INTAKE FORM

Private Application for Treatment

Patient Name: ______________________________**Date:** _______________ **Date of Birth:** _________

Address: _____________________ **City:** ______________ **State:**_______ **Zip**______

Home: __________________ **Cell:** __________________ **Work:** _____________

Employer: _____________________________________ **Occupation:**____________________

Soc.Sec. # ____________________ **Email Address**___________________________________

Marital Status: M ☐ **S**☐ **W**☐ **D**☐

In Case of Emergency Contact: ______________________**Phone # :**___________________

Whom may we thank for referring you? ____

Primary Insurance Name of Insurance Company:

____

Insured Name: _________________________**Relationship to insured**

____

Insured ID#: ______________________________ **Group #:** ___________________________

Additional Insurance Name of Insurance Company: _________________________________

Insured Name: ____________________________ **Relationship to insured**_______________

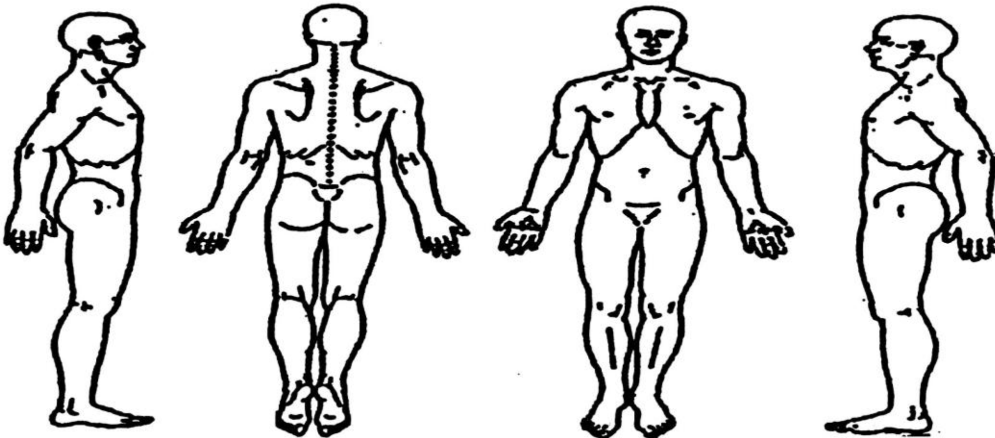
Insured ID#: _______________________________ **Group #:** __________________________

Signature on File h I authorize the use of this form on all my insurance submissions. I authorize release of information to all my Insurance Companies. I understand that I am responsible for any payment due for services rendered. I authorize my doctor to act as my agent in helping me obtain payment from my Insurance. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original

Patient Signature _________________________________ **Date**: ______________________

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation ☐ Slip & Fall ☐ Other

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)

First Complaint:

4. How would you describe the type of pain? ☐ Neck Pain ☐ Upper Back Pain ☐ Mid Back Pain ☐ Low Back Pain ☐ Shoulder Pain ☐ Other:__________

☐ 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*)

Second Complaint:

4A. How would you describe the type of pain? ☐ Neck Pain ☐ Upper Back Pain ☐ Mid Back Pain ☐ Low Back Pain ☐ Shoulder Pain ☐ Other:__________

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly

☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other:___________________

5A. How are your symptoms changing with time?
☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6A. 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*)

Third Complaint:

4B. How would you describe the type of pain? ☐ Neck Pain ☐ Upper Back Pain ☐ Mid Back Pain
☐ Low Back Pain ☐ Shoulder Pain ☐ Other:__________

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other:___________________

5B. How are your symptoms changing with time?
☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6B. 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*)

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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?
☐ Since the Accident: ☐ Other____

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

13. What aggravates your problem?
____: ☐ Always there.

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

☐ Getting worse ☐ Not going away ☐ Other: ______________

☐ Prevents me from doing normal daily activities.

15. What is your: Height___________ Weight _____________ Age ___________

Occupation ____

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