New Patient Intake Form

Name: Date:

Please complete ALL the sections.

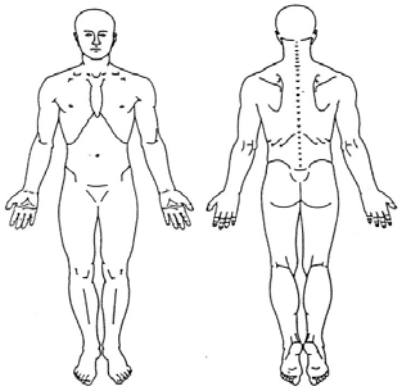
Where is your pain: _____

Pain Intensity: ***On a scale from 0 to 10 how would you grade the pain/symptom(s) with 0 being no symptoms and 10 the most severe?***

0 1 2 3 4 5 6 7 8 9 10

MARK WHERE YOU HAVE YOUR PAIN

Numbness (#) Burning "X" Stabbing (/)
Pins & Needles (o) Dull Ache (+) Pain (*)



Mechanism of Injury: ***How did you injury yourself?***

_____

Onset: ***When did your symptoms start?***

_____

Frequency: Primary signs and symptoms are present approximately:

□0-25% □26-50% □51-75% □76-100% **OF THE** □day □week □month

Timing: Primary signs and symptoms are present on what type of basis:

□Infrequent □Intermittent □Occasional □Episodic □Frequent □Constant

When are your symptoms WORST?

□morning □midday □end of the day □at night □throughout the day □at night with pain

When are your symptoms BETTER?

□morning □midday □end of the day □at night □throughout the day □at night with pain

How would you describe the quality of your pain?

□dull □sharp □sharp w/ movement □throbbing □burning □deep □aching
□tingling □stabbing □cramping □pinprick □numbness □radiating □Other: _____

Radiating: ***Does your pain travel to the following regions?***

□shoulder □upper arm □arm to hand
□buttock □upper leg □leg above the knee □leg below the knee □leg to the foot

Aggravating factors: ***Which activities aggravate (increase) your symptoms?***

□sitting □standing □walking □bending □stooping □lifting
□sleeping □sneezing □coughing □straining □reaching □twisting
□looking up □looking down □movement □rest □lying face up □driving
□typing □scooping □household chores □exercise □stair stepping

Relieving factors: Which activities relieve (decrease) your symptoms?

□sitting □standing □lying down □knees are bent up □leaning against support
□no movement occurs □movement occurs □heat is applied □ice is applied
□pain relief gel □ibuprofen is taken □medication is used □adjustments are provided
□rest occurs □stretching/exercise is used

Medications: Please check which one(s) apply to you

□ I am taking prescription medication as prescribed by my medical physician.
□ I am taking over-the-counter medication of my own accord.
□ I have received a prescription for additional services from my medical provider.
□ I am not taking any prescription medication nor any over-the-counter medication.
□ I am taking the following medications: _____

_____

_____

_____

_____

Name: Date:

Medical History

Medical Conditions (Please check which ones apply to you)

□Arthritis □Cancer □Diabetes □Heart Disease
□Hypertension □Psychiatric Illness □Skin Disorder □Stroke

Surgeries: (Please check which ones apply to you)

□Appendectomy □Cardiovascular Procedure □Cervical Disc Procedure □Hysterectomy
□Joint Replacement □Laminectomies □Radical prostatectomy □Trans-urethral prostate surgery

Allergies: (Please check which ones apply to you)

□Bee Stings □Eggs □Fish and Shellfish □Latex
□Lotions/Creams □Medications □Milk or Lactose □Peanut
□Seasonal □Soy □Sulfites □Wheat/Gluten

Social History: (Please check which ones apply to you)

□Caffeine used occasionally □Caffeine used often □Chew tobacco occasionally □Chew tobacco often
□Drink alcohol occasionally □Drink alcohol often □Exercise not at all □Exercise occasionally
□Exercise often □Experience stress occasionally □Experience stress often □Smoke 1 pk or less/day
□Smoke 1+pk/day □Wear seat belt always □Wear seatbelt never □Wear seatbelt usually

Family History: (Please check which ones apply to you)

□Arthritis (parent) □Arthritis (sibling) □Cancer (parents) □Cancer (sibling)
□Cholesterol (parent) □Cholesterol (sibling) □Diabetes (parent) □Diabetes (sibling)
□Heart problems (parent) □Heart problems (sibling) □High blood pressure (parent) □High blood pressure (sibling)
□Psychiatric (parent) □Psychiatric (sibling) □Stroke (parent) □Stroke (sibling)

Substance Use: (Please check which ones apply to you)

□Alcohol (past) □Alcohol (present) □Amphetamines (past) □Amphetamines (present)
□Barbiturates (past) □Barbiturates (present) □Cocaine (past) □Cocaine (present)
□Crystal Meth □Heroin (past) □Heroin (present) □Marijuana (past)
□Marijuana (present)

Male Children: (Check if you are:)

□Under 6 years old □Under 10 years old □Under 19 years old

Female Children: (Check if you are:)

□Under 6 years old □Under 10 years old □Under 19 years old

Occupational Activities: (Please check which one(s) apply to you)

□Administration □Business Owner □Clerical/secretarial □Computer User
□Construction □Daycare/Childcare □Executive/legal □Food service industry
□Healthcare □Heavy equipment operator □Heavy manual labor □Home services
□Household □Light manual labor □Manufacturing □Medium manual labor
□Military □Police/fire □Professional services □Retail worker

Name: Date:

Review of Systems

Cardiovascular

Present	Past	No	
□	□	□	Poor circulation
□	□	□	High blood pressure
□	□	□	Aortic aneurism
□	□	□	Heart disease
□	□	□	Vascular disease
□	□	□	Heart attack
□	□	□	Chest pain
□	□	□	High cholesterol
□	□	□	Pace maker
□	□	□	Jaw pain
□	□	□	Irregular heartbeat
□	□	□	Swelling of legs

Genitourinary

Present	Past	No	
□	□	□	Kidney disease
□	□	□	Lower side pain
□	□	□	Burning urination
□	□	□	Frequent urination
□	□	□	Blood in urine
□	□	□	Kidney stone
□	□	□	Prostate

Hematologic/Lymphatic

Present	Past	No	
□	□	□	Hepatitis
□	□	□	Blood clots
□	□	□	Cancer
□	□	□	Easy Bruising
□	□	□	Easy bleeding
□	□	□	Fever/Chills/Sweats

Respiratory

Present	Past	No	
□	□	□	Asthma
□	□	□	Tuberculosis
□	□	□	Shortness of Breath
□	□	□	Emphysema
□	□	□	Cold/Flu
□	□	□	Cough/Wheezing
□	□	□	Pneumonia
□	□	□	Bronchitis

Ears/Nose/Throat

Present	Past	No	
□	□	□	Dizziness
□	□	□	Hearing loss
□	□	□	Sinus infection
□	□	□	Nosebleed
□	□	□	Sore throat
□	□	□	Difficulty swallowing
□	□	□	Bleeding gums

Eyes

Present	Past	No	
□	□	□	Glaucoma
□	□	□	Double vision
□	□	□	Blurred vision
□	□	□	Cataracts

Integumentary

Present	Past	No	
□	□	□	Skin lesions
□	□	□	Skin ulcers
□	□	□	Skin disease
□	□	□	Eczema
□	□	□	Psoriasis
□	□	□	Rashes

Allergic/Immunologic

Present	Past	No	
□	□	□	Hives
□	□	□	Immune disorder
□	□	□	HIV/AIDS
□	□	□	Allergy shots
□	□	□	Cortisone use
□	□	□	Latex
□	□	□	Bee stings
□	□	□	Lotion/Cream

Gastrointestinal

Present	Past	No	
□	□	□	Gallbladder problems
□	□	□	Bowel problems
□	□	□	Constipation
□	□	□	Liver problems
□	□	□	Ulcers
□	□	□	Diarrhea
□	□	□	Nausea/Vomiting
□	□	□	Bloody Stools
□	□	□	Poor appetite
□	□	□	GERD

Name: Date:

Musculoskeletal

Present	Past	No	
□	□	□	Gout
□	□	□	Arthritis
□	□	□	Joint stiffness
□	□	□	Muscle weakness
□	□	□	Osteoporosis
□	□	□	Broken bones
□	□	□	Joints replaced

Endocrine

Present	Past	No	
□	□	□	Thyroid disease
□	□	□	Diabetes
□	□	□	Hair loss
□	□	□	Menopausal
□	□	□	Menstrual problems

Psychiatric

Present	Past	No	
□	□	□	Depression
□	□	□	Anxiety disorders
□	□	□	Unusual stress

Constitutional

Present	Past	No	
□	□	□	Weight loss/gain
□	□	□	Energy level problem
□	□	□	Difficulty sleeping

Neurological

Present	Past	No	
□	□	□	Babinski
□	□	□	Stroke
□	□	□	Seizures
□	□	□	Head injury
□	□	□	Brain aneurysm
□	□	□	Numbness
□	□	□	Severe headaches
□	□	□	Pinched nerves
□	□	□	Parkinson's disease
□	□	□	Carpal tunnel
□	□	□	Spinning/balance

Cancer

Present	Past	No	
□	□	□	Skin cancer
□	□	□	Breast cancer
□	□	□	Ovarian cancer
□	□	□	Prostate cancer
□	□	□	Colon cancer
□	□	□	Lung cancer
□	□	□	Brain cancer

Name: _____ Date: _____

Patient Health Questionnaire

1. How often do you experience your symptoms?

□Constant (76-100% of the day) □Frequent (51-75% of the day)

□Occasionally (26-50% of the day □Intermittently (0-25% of the day)

2. What describes the nature of your symptoms?

□Sharp □Dull Ache □Numb □Shooting □Burning □Tingling

3. How are your symptoms changing?

□Getting better □Not changing □Getting worse

4. During the past 4 weeks, indicate the average intensity of your symptoms:

0 (none) 1 2 3 4 5 6 7 8 9 10(unbearable)

5. During the past 4 weeks, how much pain interfered with your normal work (including both work outside the home and housework

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

6. During the past 4 weeks, how much of the time has your condition interfered with your social activities?

□All of the time □Most of the time □Some of the time □A little of the time □None

7. In general would you say your overall health right now is…?

□Excellent □Very good □Good □Fair □Poor

8. Who have you seen for your symptoms?

□No one □Other chiropractor □Medical doctor □Physical therapist □Other _____

9. What treatment did you receive for your symptoms?

□Adjustments □Physical therapy □Medication □Surgery □Other_____

10. When did you receive treatment?

□In the last mo □2-3 mo □3-6 mo □6 mo-1y ago □1-2 yrs ago □2-5 yrs ago □5-10 yrs ago

11. What tests have you had for your symptoms?

□X-rays □MRI □CT Scan □Other _____

12. When were these tests done?

□In the last mo □2-3 mo □3-6 mo □6 mo-1y ago □1-2 yrs ago □2-5 yrs ago □5-10 yrs ago

13. Have you had similar symptoms in the past? □Yes □No

14. If you have received treatment in the past for the same or similar symptoms, who did you see?

□This office □Other chiropractor □Medical doctor □Physical therapist □Other _____

15. What is your occupation?

□Professional/executive □White collar/secretarial □Tradesperson □Laborer

□Homemaker □FT Student □Retired □Other_____

16. If you are not retired, a homemaker, or a student, what is your current work status?

□Full time □Part time □Self-employed □Unemployed □Off work □Other_____