

Patient Intake Form



Patients Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

1) Please choose the location(s) of your problem(s):

Headaches	Shoulder	Hand	Legs
Jaw	Arm	Mid back	Knee
Neck	Elbow	Low back	Ankle
Upper back	Wrist	Hip	Foot

Other: \_\_\_\_\_

2) What is your height? \_\_\_\_\_ ft. \_\_\_\_\_ in.

3) How much do you weight? \_\_\_\_\_ lbs.

4) DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

5) Occupation:

Trader	Professional/Executive	White Collar	Tradesperson	Retired
Laborer	Homemaker	Truck driver	Student	Unemployed

Other: \_\_\_\_\_

6) In general, how do you rate your overall health?

Excellent	Very good	Good	Fair	Poor
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7) What kind of exercise do you perform?

Strenuous	Moderate	Light	None
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8) Do you have an immediate family member with any of the following?

Rheumatoid arthritis	Heart problems	Diabetes
Cancer	Lupus	ALS

Other: \_\_\_\_\_

9) Please check all that apply to you in the appropriate column:

- |                          |                                               |                          |                                                      |                          |                                                  |
|--------------------------|-----------------------------------------------|--------------------------|------------------------------------------------------|--------------------------|--------------------------------------------------|
| <b>Past</b>              | <b>Present</b>                                | <b>Past</b>              | <b>Present</b>                                       | <b>Past</b>              | <b>Present</b>                                   |
| <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   | <b>For Females Only</b>  |                                                  |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain      | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite            | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills     |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain              | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement    |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Ulcer                       | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy               |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis                   |                          |                                                  |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder |                          |                                                  |
| <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: _____         |                          |                                                      |                          |                                                  |

Patient Intake Form

10) Please list all prescription medications you are currently taking:

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11) Please list all supplements you are currently taking:

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12) Please list all surgical procedures you have had:

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13) What do you do at work?

Sits most of the day	Sits about half the day	Sits a little of the day
Stands most of the day	Stands about half the day	Stands a little of the day
Computer most of the day	Computer about half the day	Computer a little of the day
On the phone most of the day	On the phone about half the day	On the phone a little of the day
Drives most of the day	Drives about half the day	Drives a little of the day
Performs manual labor most of the day	Reads a lot about half the day	Travels frequently a little of the day
None		

Other: \_\_\_\_\_

14) What do you do outside of work?

Aerobics	Skiing	Basketball	Soccer	Baseball	Softball
Bicycling	Swimming	Football	Tennis	Golf	Triathlons
Hiking	Volleyball	Ice hockey	Walking	Inline skating	Weight lifting
Jogging	Working out	Martial arts	Yoga	Rock climbing	Other

15) Have you had any hospitalizations?

Yes	No	Previously mentioned
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16) Have you seen a chiropractor before?

Yes	No
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17) Have you had any significant past trauma?

Yes	No
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18) Is there anything else you think I should know?

Yes	No
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20) What did the patient score on the revised neck oswestry index? \_\_\_\_\_

21) What did the patient score on the revised lower back oswestry index? \_\_\_\_\_