PATIENT INTAKE FORM **DATE:**_____

PATIENT INFORMATION

First Name: Middle Initial:

Last Name:

Address:

City: State: Zip:

Social Security #:

Driver's License #:

Sex: ☐ Male ☐ Female

Date of Birth: Your age:

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

SPOUSE

Spouse's Name:

Spouse's Birthdate:

Spouse's SSN#:

Spouse's Employer:

CONTACT NUMBERS

Home phone #:

Work phone #:

Cell phone #:

E-mail:

Emergency contact:

Contact phone #:

Relationship to Contact:

REFERRAL

Whom may we thank for referring you?

HEALTH INSURANCE INFORMATION

Employer:

Occupation:

Primary Insurance:

Insured Person's Name:

Insured's Birthdate:

Relationship to Patient:

Group #:

ID #:

Secondary Insurance:

Insured Person's Name:

Insured's Birthdate:

Relationship to Patient:

Group #:

ID #:

PATIENT CONDITION

Main Complaint:

Are you having any symptoms today? ☐ Yes ☐ No

How often do you have some symptoms?

☐ Constantly ☐ Daily ☐ Weekly ☐ Monthly

Does it interfere with: (check all that apply)

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Is it uncomfortable to: (check all that apply)

☐ Sit ☐ Stand ☐ Walk ☐ Bend ☐ Lay ☐ Lift

Is condition due to an accident? ☐ Yes ☐ No

If an accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Date of accident: Time:

To whom have you made an accident report?

☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ Police

Have you seen another doctor for this? ☐ No ☐ Yes

Doctor's Name:

Diagnosis:

Treatment:

Results:

Were you hospitalized? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Due date:

Do you wear a shoe lift? ☐ No ☐ Yes

Indicate other complaints & areas of symptoms or pain:

☐ Headache	☐ Neck	☐ Shoulder	☐ Chest
☐ Arm	☐ Hand	☐ Mid back	☐ Low back
☐ Thigh	☐ Knee	☐ Leg	☐ Foot

On the diagram of the person below, place an "X" over the areas of your body where you feel pain or stiffness. i.e. (dull, achy, burning, tingling, numbness, sharp, shooting)

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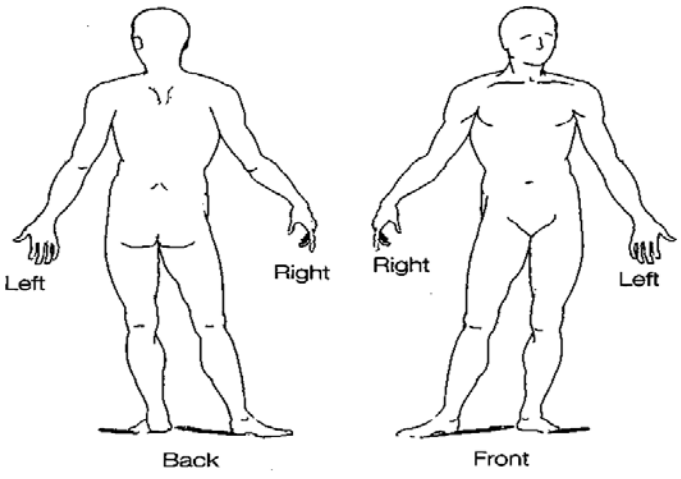

PRESENT & PAST HEALTH HISTORY

PATIENT'S NAME:_____

DATE:_____

HEALTH HISTORY

What care have you already tried for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic ☐ None

Date of last physical exam:

Date of last spinal exam:

Date of last spinal x-ray:

Date of last MRI/CT Scan/Bone Scan:

EXERCISE

☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACTIVITY

☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

HABITS

☐ Smoking ☐ Alcohol ☐ Caffeine ☐ High Stress

MEDICATIONS

☐ Pain Medicine ☐ Muscle Relaxants ☐ Arthritis medicine

☐ Blood Pressure Meds ☐ Insulin ☐ Anti-Depressants

Others:

VITAMINS / HERBS / MINERALS

ALLERGIES

PRIOR INJURIES OR SURGERIES

Major Accidents/Falls:

Head Injuries:

Broken Bones:

Dislocations:

Surgeries:

NAMES OF CHILDREN	AGES
1	
2	
3	
4	
5	
6	

PAST CONDITIONS

Please check every prior condition you have had:

☐ AIDS/HIV	☐ Migraine Headaches
☐ Alcoholism	☐ Miscarriage
☐ Aneurysm	☐ Multiple Sclerosis
☐ Appendicitis	☐ Neck Surgery
☐ Asthma	☐ Osteoporosis
☐ Back Surgery	☐ Pacemaker
☐ Bleeding Disorders	☐ Parkinson's Disease
☐ Bronchitis	☐ Pinched Nerve
☐ Cancer	☐ Pneumonia
☐ Diabetes	☐ Prostate Problem
☐ Emphysema	☐ Prosthesis
☐ Epilepsy	☐ Psychiatric Care
☐ Fractures	☐ Rheumatoid Arthritis
☐ Gall Bladder Surgery	☐ Scoliosis
☐ Glaucoma	☐ Stroke
☐ Goiter	☐ Thyroid Problems
☐ Gout	☐ Tonsillitis
☐ Heart Disease	☐ Tuberculosis
☐ Hepatitis	☐ Ulcers
☐ High Cholesterol	☐ Other_____
☐ Hypertension	☐ Other_____
☐ Kidney Disease	☐ Other_____
☐ Liver Disease	☐ Other_____

VEHICLE CRASH HISTORY

PATIENT'S NAME:_____

SOCIAL SECURITY #:_____

DATE:_____

VEHICLE CRASH INFORMATION

What is your main concern or complaint?

Is your condition due to a crash? ☐ No ☐ Yes

Date of crash: Time: State:

To whom have you made an crash report?

☐ Your Auto Insurance ☐ Other Parties Auto Insurance

Someone ticketed? ☐ No ☐ Yes ☐ Me ☐ Them

For what?

How did the crash happen?

Please draw the accident:

N

|

|

|

W----------E

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|

S

Your auto insurance:

Address:

Phone #:

Claim #:

Adjuster:

Their auto insurance:

Address:

Phone #:

Claim #:

Adjuster:

Have you retained an attorney? ☐ No ☐ Yes

Attorney's Name:

Address:

Phone #:

CRASH INFORMATION

Were you the driver? ☐ No ☐ Yes

Were you a passenger? ☐ No ☐ Yes

☐ Front ☐ Back ☐ Right Side ☐ Left Side ☐ Middle

Was it your vehicle? ☐ No ☐ Yes

Did you have your seat belt on? ☐ No ☐ Yes

Did any airbags go off? ☐ No ☐ Yes ☐ Front ☐ Side

Were you reclined or turned in your seat? ☐ No ☐ Yes

What were the road conditions?

☐ Dry ☐ Wet ☐ Icy ☐ Snowy ☐ Other:_____

How fast do you think you were going? mph

What type of vehicle were you in? Year & Make

What part of your vehicle was struck; front, rear, side?

Were there other people in the car? ☐ No ☐ Yes

If yes, names & ages:

Did your vehicle hit anything? ☐ No ☐ Yes

If yes, ☐ Vehicle ☐ Post ☐ Embankment ☐ Other: _____

If your vehicle collided with another car, where?

☐ Front ☐ Back ☐ Side ☐ Corner: _____

Was the other vehicle a:

☐ Car ☐ Truck ☐ Motorcycle ☐ Other: _____

What part of the other vehicle was struck: front, rear, side?

Do you remember if you hit anything in your vehicle?

i.e.: head on window, chest on steering wheel?

☐ No ☐ Yes If yes, what part & how?

Have you been injured like this before? ☐ No ☐ Yes

Explain:

Where did you go after the crash? ☐ Home ☐ Work

Or you go to a doctor or hospital? ☐ No ☐ Yes

Other doctors seen for this? ☐ No ☐ Yes

Doctor's Name:

Diagnosis:

Treatment:

Results:

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INITIAL CONSULTATION

PATIENT'S NAME:_________________________

DATE:___________________

PRIMARY COMPLAINT	
Primary Location	as listed
Pain symptom or character	as listed
Pain Scale_____/10	as listed
Positional Occasional Intermittent Constant	
Radiates to	no
Aggravated with	as listed
Relieves with	nothing
Worse in: morning midday evening night constant	
Cause	
Gradual / Sudden	
Date of onset (recent)	
Acute / Chronic	

SECONDARY COMPLAINT	
Secondary Location	as listed
Pain symptom or character	as listed
Pain Scale_____/10	as listed
Positional Occasional Intermittent Constant	
Radiates to	no
Aggravated with	as listed
Relieves with	nothing
Worse in: morning midday evening night constant	
Cause	
Gradual / Sudden	
Date of onset (recent)	
Acute / Chronic	

INITIAL DIAGNOSES

NOTES