PATIENT INTAKE

COMPREHENSIVE SPINAL CARE

1. WHO ARE YOU?

FIRST NAME _____ LAST NAME _____ DATE OF BIRTH / / GENDER _____

PREFERRED NAME / NICKNAME _____ OCCUPATION _____ SSN (ONLY IF REQUESTED) _____

[ ] PHONE _____ [ ] home [ ] work [ ] cell E-MAIL (FOR DOCTOR COMMUNICATION ONLY) _____ [ ] join our mailing list.

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

How did you find us? [ ] Yelp [ ] Google [ ] internet [ ] friend/family _____* [ ] other

2. HOW CAN WE HELP?

What's the primary reason for your visit? _____*

What best describes your issues?
[ ] I'm experiencing a sudden onset of pain.
[ ] I'm having a flare up of a re-occurring issue.
[ ] I've had an injury or trauma that hasn't fully healed.

What would you like to improve? [CHECK ALL THAT APPLY]

[ ] pain relief [ ] fix limitation / dysfunction [ ] long term wellness
[ ] improve posture [ ] weight loss [ ] cleanse / detox
[ ] improve flexibility [ ] strength conditioning [ ] _____

Have you ever seen a chiropractor?

[ ] never [ ] a few times
[ ] once [ ] many times
/ / LAST VISIT

3. TELL US ABOUT YOUR PRIMARY ISSUE.

How long ago did it begin? _____*

Do you know what caused it? _____
[ ] work-related
[ ] automobile accident

What does it feel like? [CHECK ALL THAT APPLY]

[ ] stabbing [ ] burning [ ] stiff
[ ] dull ache [ ] numb [ ] sore
[ ] throbbing [ ] tingling [ ] other _____

How often do you feel it?

[ ] daily, _____ hours per day
[ ] weekly, _____ days per week
[ ] monthly, _____ days per month

How intense is the discomfort? [CHECK MULTIPLE IF IT VARIES]

[ ] mild
[ ] moderate
[ ] severe

Does the discomfort travel anywhere else? [CHECK ALL THAT APPLY]

[ ] head [ ] shoulder [ ] mid back [ ] thigh
[ ] neck [ ] arm [ ] lower back [ ] lower leg
[ ] face [ ] hand [ ] hip [ ] foot

What makes it better? [CHECK ALL THAT APPLY]

[ ] activity [ ] heat [ ] other _____
[ ] rest [ ] ice
[ ] stretching [ ] medication

What makes it worse? [CHECK ALL THAT APPLY]

[ ] activity [ ] driving
[ ] inactivity [ ] walking
[ ] sitting [ ] other _____

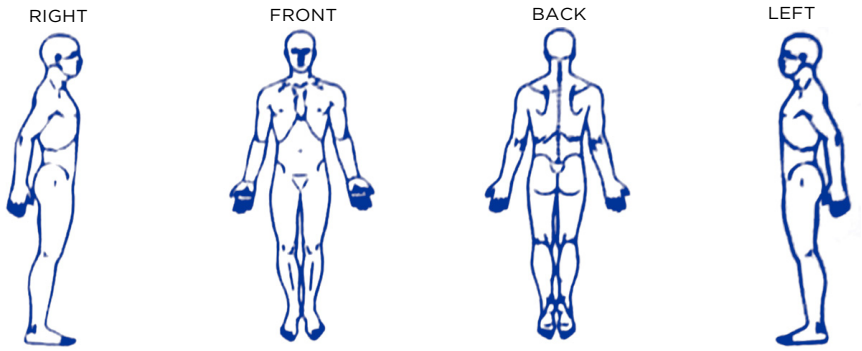
Have you seen other practitioners for this issue? [CHECK ALL THAT APPLY]

[ ] chiropractor [ ] medical doctor [ ] physical therapist [ ] acupuncturist [ ] massage therapist

4. SHOW US WHERE IT HURTS.

Draw letters at the locations of any of the following symptoms:

P - General Pain
S - Stabbing
N - Numbness
A - Aching
T - Tingling
F - Stiffness
B - Burning



5. HOW HAS YOUR QUALITY OF LIFE BEEN IMPACTED?

Sleep

- [ ] I can sleep normally
- [ ] I have restless sleep due to these issues
- [ ] I am losing sleep due to these issues
- [ ] I can't sleep due to these issues

Activities of Daily Living

(bathing, getting dressed, caring for self or others, chores, errands)

- [ ] I can perform these normally
- [ ] I can perform these but I experience discomfort
- [ ] I have pain and difficulty performing these
- [ ] I can't perform these due to pain / limitation

Occupation

- [ ] I can perform my occupation normally
- [ ] I can perform my occupation but I experience discomfort
- [ ] I have pain and difficulty performing my occupation
- [ ] I can't perform my occupation due to pain / limitation

Lifestyle / Exercise

(hobbies, exercise, other activities)

- [ ] I can perform these normally
- [ ] I can perform these but I experience discomfort
- [ ] I have pain and difficulty performing these
- [ ] I can't perform these due to pain / limitation

6. TELL US ABOUT YOUR HEALTH.

_____ HEIGHT _____ WEIGHT _____ BLOOD PRESSURE

Do you use... [ ] alcohol _____ IF SO HOW OFTEN? [ ] tobacco _____ IF SO HOW OFTEN?

We may have direct contact with your skin during examination and treatment. Do you have any condition which is communicable through skin-on-skin contact, or any blood born condition? _____ CONDITION (IF ANY)

Any current or past issues with the following body systems? Mark "C" for Current and "P" for Past.

[ ] eyes	[ ] nails	[ ] throat	[ ] heart	[ ] osteoporosis / penia	[ ] nervous system	[ ] vascular system
[ ] ears	[ ] skin	[ ] bones	[ ] neuropathy	[ ] digestive system	[ ] urinary system	[ ] endocrine system
[ ] nose	[ ] hair	[ ] joints	[ ] diabetes	[ ] respiratory system	[ ] reproductive system	[ ] other _____

Briefly describe anything you marked above: _____

Tell us a little about your medical history:

CURRENT MEDICATIONS OR TREATMENTS	KNOWN ALLERGIES DRUG OR COMMON	PAST SURGERIES WITH APPROXIMATE DATES	MAJOR TRAUMA OR ILLNESS

By signing below, I hereby affirm that all of the above information is accurate and honest to the best of my knowledge.

_____ SIGNATURE _____ PRINTED NAME _____ / / DATE