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
- ☐ improve posture
- ☐ improve flexibility
- ☐ fix limitation / dysfunction
- ☐ weight loss
- ☐ strength conditioning
- ☐ long term wellness
- ☐ cleanse / detox
- ☐ _____

Have you ever seen a chiropractor?

☐ never ☐ once ☐ a few times ☐ 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
- ☐ dull ache
- ☐ throbbing
- ☐ burning
- ☐ numb
- ☐ tingling
- ☐ stiff
- ☐ sore
- ☐ 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
- ☐ neck
- ☐ face
- ☐ shoulder
- ☐ arm
- ☐ hand
- ☐ mid back
- ☐ lower back
- ☐ hip
- ☐ thigh
- ☐ lower leg
- ☐ foot

What makes it better? [CHECK ALL THAT APPLY]

- ☐ activity
- ☐ rest
- ☐ stretching
- ☐ heat
- ☐ ice
- ☐ medication
- ☐ other _____

What makes it worse? [CHECK ALL THAT APPLY]

- ☐ activity
- ☐ inactivity
- ☐ sitting
- ☐ driving
- ☐ walking
- ☐ 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.

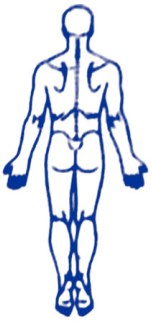
Enter letters at the locations of any of the following symptoms:

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

RIGHT

FRONT

BACK



LEFT

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