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

7) What kind of exercise do you perform?

Strenuous	Moderate	Light	None

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:

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

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

_____

11) Please list all supplements you are currently taking:

_____

12) Please list all surgical procedures you have had:

_____

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

16) Have you seen a chiropractor before?

Yes	No

17) Have you had any significant past trauma?

Yes	No

18) Is there anything else you think I should know?

Yes	No

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? _____