PATIENT INTAKE FORM

Today's Date: ______________________________

Patient Name: ______________________________ DOB: ______________

Social Security: ______________ Gender: ______ Marital Status: ________ Race: ____ Age: ____

Address: ______________________________

Employer: ______________________________

Employer Address: ______________________________

Home Phone: ______________________ May we leave a detailed message? ❑ Yes ❑ No

Work Phone: ______________________ May we leave a detailed message? ❑ Yes ❑ No

Cell Phone: ______________________ May we leave a detailed message? ❑ Yes ❑ No

E-mail Address: ______________________________

Emergency Contact Name: ______________________________

Emergency Contact Phone Number: ______________ Relationship: ______________

IF WORK ACCIDENT OR MOTOR VEHICLE ACCIDENT PLEASE NOTIFY FRONT DESK

Primary Insurance Information (please be sure to provide a copy of the card)

Carrier Name: ______________________________

Carrier Address: ______________________________

Carrier Phone Number: ______________________________

Insured Name (If other than patient): ______________________________

Patient relationship to insured (if other than insured): ______________________________

Insured ID Number: ______________ Group Number: ______________

Insured's Employer: ______________ Employer Phone: ______________

Secondary Insurance Information (please be sure to provide a copy of the card)

Carrier Name: ______________________________

Carrier Address: ______________________________

Carrier Phone Number: ______________________________

Insured Name (If other than patient): ______________________________

Patient relationship to insured (if other than insured): ______________________________

Insured ID Number: ______________ Group Number: ______________

Insured's Employer: ______________ Employer Phone: ______________

Please complete the following section if patient is a minor/dependent only

Guarantor Name: ______________________________

Relationship to Patient: ______________ DOB: ______________

Address: ______________________________

Home Phone: ______________________ May we leave a detailed message? ❑ Yes ❑ No

Work Phone: ______________________ May we leave a detailed message? ❑ Yes ❑ No

Cell Phone: ______________________ May we leave a detailed message? ❑ Yes ❑ No

E-mail Address: ______________________________

PLEASE NOTE: If a Motor Vehicle Accident or Work Accident has brought you to our office today please notify our front desk as additional paperwork may be needed.

1. Name of Doctor who referred you: ______________________ ❑ None
2. Name of Primary Care Physician: ______________________
3. What is the reason for your visit today? Where do you hurt? ______________________
4. How long have you had this problem? ______________________
5. What caused your problem? ❑ Injury ❑ Motor Vehicle Accident ❑ Work Accident ❑ Unknown
6. Give a brief history of what caused your pain to start. If accident, date: ______________________
____
____
____
7. Have you previously been treated for the same symptoms before this started? ❑ Yes ❑ No
   a. If yes, When? ______________________ Diagnosis: ______________________
   b. Did you fully recover? ❑ Yes ❑ No If yes, when? ______________________
8. Check all that apply to your symptoms:
   a. Pain Quality: ❑ Sharp ❑ Aching ❑ Burning ❑ Shooting ❑ Constant ❑ Intermittent
   b. Increase Pain: ❑ Sitting ❑ Laying Down ❑ Walking ❑ Bending ❑ Weather ❑ Coughing/Sneezing
   c. Decrease Pain: ❑ Sitting ❑ Laying Down ❑ Walking ❑ Bending ❑ Weather ❑ Stretching
   d. Associated Symptoms: ❑ Weakness ❑ Numbness ❑ Tingling ❑ Fever ❑ Pain Wakes At Night
   ❑ Insomnia ❑ Sexual Dysfunction ❑ Bowel/Bladder Problems ❑ Weight loss: ______________
   ❑ Other: ______________________
9. Previous Treatment For:

Previous Treatment For:	Treatment	Helpful	On Going	Comments:
Back Brace?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	______
Neck Brace?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	______
Tens Unit?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	______
Physical/Occupational Therapy?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	______
Psychological Evaluation?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	Who? ______
Chiropractic Care?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	Who? ______
Nerve Blocks?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	Who? ______
Surgeries?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	Who? ______

10. Radiological Studies

Radiological Studies		Part of Body	Date	Where	Results
X-Rays	❑ Yes ❑ No	______	______	______	______
MRI	❑ Yes ❑ No	______	______	______	______
CT Scan	❑ Yes ❑ No	______	______	______	______
EMG (Nerve Study)	❑ Yes ❑ No	______	______	______	______
Myleogram	❑ Yes ❑ No	______	______	______	______
Other	❑ Yes ❑ No	______	______	______	______

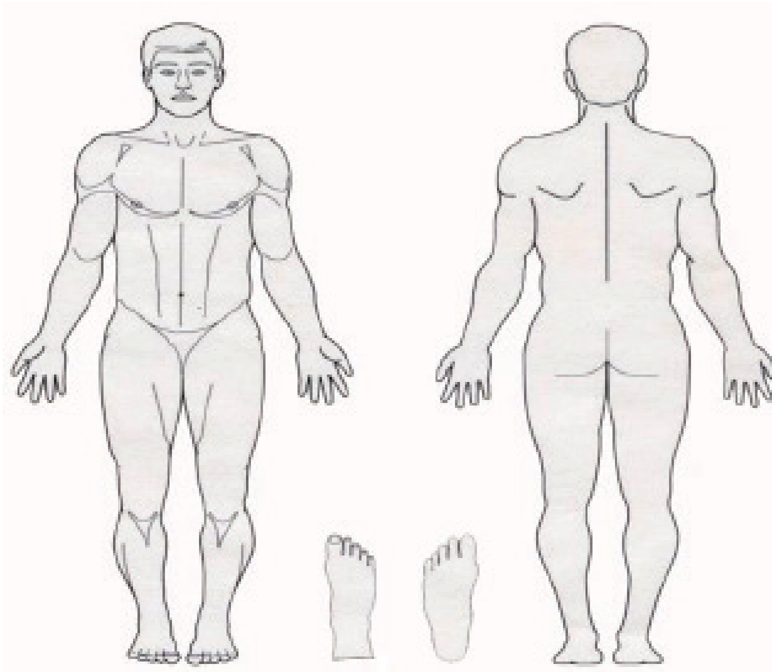
11. How would you rate your pain today? Circle one: ❑ 0 No Pain ❑ 1-3 Mild ❑ 4-6 Moderate ❑ 7-10 Severe
12. Currently taking medications? ❑ Yes ❑ No If yes, please list below:

Name of Medication	Amount Daily	Reason	Date Last Taken
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

13. Are you currently taking any blood thinners? ❑ Yes ❑ No If yes, what? ______________________

Doctors Notes:
____
____
____
____

14. Mark the diagram below as follows: A=Ache B= Burning N= Numbness P= Pins & Needles S=Stabbing O=Other



NURSE/DOCTOR NOTES

____
____
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15. Do you have any of the following allergies?
❑ IVP Dye ❑ Steroids ❑ Shellfish ❑ Novocaine ❑ Morphine ❑ Valium ❑ Aspirin ❑ Other: __________
If yes, what type of reaction: ____

16. Do you have a **Past Medical History** of any of the following?

CNS

Cerebral Aneurysm	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Brain Tumor	❑ Yes	❑ No
Seizure Disorder	❑ Yes	❑ No
Neuropathy	❑ Yes	❑ No

GASTROINTESTINAL

Hiatal Hernia	❑ Yes	❑ No
Ulcer	❑ Yes	❑ No
Other: __________		

BONE/MUSCLE

Arthritis	❑ Yes	❑ No
Fibromyalgia	❑ Yes	❑ No

GENITOURINARY

Kidney Disease	❑ Yes	❑ No
Are you pregnant?	❑ Yes	❑ No

CARDIOVASCULAR

Hypertension	❑ Yes	❑ No
Valve Disease	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No
Date: __________		
Irregular Heartbeat	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No

RESPIRATORY

Asthma	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No
Bronchitis	❑ Yes	❑ No

PSYCHIATRIC

Depression	❑ Yes	❑ No
Date: __________		
Anxiety	❑ Yes	❑ No

METABOLIC

Liver Disease	❑ Yes	❑ No
Diabetes/Types	❑ Yes	❑ No
Thyroid	❑ Yes	❑ No
Bleeding Disorder	❑ Yes	❑ No
What: __________		
Other weight?	❑ Yes	❑ No

INFECTIOUS

Hepatitis/Types	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Types/Treatment: __________		

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17. **Review of Symptoms**

CONSTITUTIONAL

Fever	❑ Yes	❑ No
Wieght Loss	❑ Yes	❑ No
Insomnia	❑ Yes	❑ No

MUSCULOSKELETAL

Joint Pain	❑ Yes	❑ No
Joint Swelling	❑ Yes	❑ No

ENT

Sinus Headaches	❑ Yes	❑ No

OPTHALMOLOGY

Loss of Vision	❑ Yes	❑ No
Blurring of Vision	❑ Yes	❑ No

RESPIRATORY

Shortness of Breath	❑ Yes	❑ No
Cough	❑ Yes	❑ No

CARDIOLOGY

Chest Pain	❑ Yes	❑ No
Congestive Heart Failure	❑ Yes	❑ No
Leg Swelling	❑ Yes	❑ No

GASTROENTEROLOGY

Heartburn	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No

NEUROLOGY

Headache	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Seizures	❑ Yes	❑ No

UROLOGY

Frequent Urination	❑ Yes	❑ No
Recurrent UTI	❑ Yes	❑ No

ENDOCRINOLOGY

Osteoporosis	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No

PSYCHOLOGY

Depression	❑ Yes	❑ No
Sleep Disturbances	❑ Yes	❑ No
High Stress Level	❑ Yes	❑ No

18. Surgical Procedure History

Procedure	Date

Family History

19. Have any of your family had the following:

		If yes, who?				If yes, who?	
Diabetes	❑ Yes ❑ No		❑ Deceased	Alcoholism	❑ Yes ❑ No		❑ Deceased
Heart Disease	❑ Yes ❑ No		❑ Deceased	Cancer	❑ Yes ❑ No		❑ Deceased
Suicide	❑ Yes ❑ No		❑ Deceased	Neck/Back Problems	❑ Yes ❑ No		❑ Deceased
Psychiatric Disorders	❑ Yes ❑ No		❑ Deceased	Drug use	❑ Yes ❑ No		❑ Deceased

Social History

20. Are you: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single
21. Do you have children: ❑ Yes ❑ No ❑ If yes, how many? ______
22. What is your highest level of school? ______
23. Do you smoke? ❑ Yes ❑ No If yes, how much? ______
24. Do you drink alcohol? ❑ Never ❑ Social ❑ Light ❑ Moderate ❑ Heavy
25. Do you use drugs? ❑ Never ❑ Occasionally ❑ Frequently ❑ If yes, what? ______
26. Do you use intravenous drugs? ❑ Yes ❑ No ❑ If yes, what? ______

Employment Information

27. Occupation at time of injury? ______ ❑ Unemployed ❑ Retired
28. Type of work at time of injury? ❑ Office/Clerical ❑ Light Labor ❑ Moderate Labor ❑ Heavy Labor
29. Current occupation? ______ ❑ Unemployed ❑ Retired
30. Current type of work? ❑ Office/Clerical ❑ Light Labor ❑ Moderate Labor ❑ Heavy Labor
31. If you are unemployed are you receiving: ❑ Disability Income ❑ Workman's Comp ❑ Retirement
32. When did you last work? ______
33. Number of hours worked per week? ______
34. If on disability, who put you on it? ______
35. Have you ever been put on work restriction? ❑ Yes ❑ No If yes, what kind? ______
36. Are you currently on work restriction? ❑ Yes ❑ No If yes, what kind? ______
37. Doctors Notes: ______

All of the above information is true and accurate to the best of my knowledge.

Patient Signature: ______ Date: ______

Provider Signature: ______ Date: ______