PATIENT INTAKE FORM – LIFE CHIROPRACTIC

Patient Name: _____ Date: _____ **1**

1. Is/are your problem related to: _____ Auto Accident _____ Worker's Compensation _____ Sports

.

2. How often do you experience your symptoms?

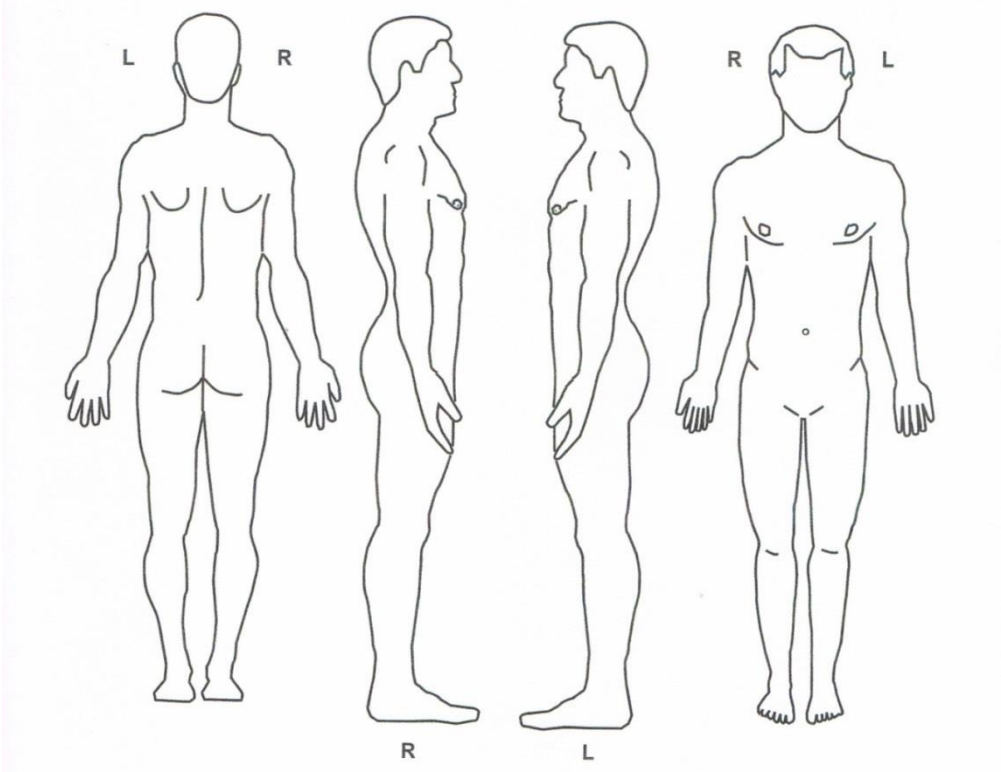
_____ **Constantly** (76-100% of the time) **Describe**: _____
_____ **Frequently** (51-75% of the time) **Describe**: _____
_____ **Occasionally** (26-50% of the time) **Describe**: _____
_____ **Intermittently** (1-25% of the time) **Describe**: _____

3. How are your symptoms changing with time?

_____ Getting Worse _____ Staying the Same _____ Getting Better _____ Fluctuating

4. Show where your symptoms are on the body diagrams. Use the highlighted letters below to describe the type of pain. ** Use an "X" to indicate the location of any scars, either traumatic or surgical.

A=Achy B=Burning DI=Diffuse DB=Difficulty Breathing DU=Dull E=Electric-like N=Numb SH=Sharp SHO=Shooting STA=Stabbing STI=Stiff T=Tingly. If present, indicate where any pain radiates (arms/legs/ribs)



Most important condition? _____ Secondary condition? _____

5. Using a scale from 0 – 10 (10 being the worst), how would you rate your problem(s)? Circle your number.

0 1 2 3 4 5 6 7 8 9 10 Most Important Condition

0 1 2 3 4 5 6 7 8 9 10 Secondary Condition

6. How much has the problem interfered with your work?
_____ Not at all _____ A little bit _____ Moderately _____Quite a bit _____Extremely

7. How much has the problem interfered with your social activities?
_____ Not at all _____ A little bit _____ Moderately _____Quite a bit _____Extremely

8. Who else have you seen for your problem? If anybody, use the letter key to rate your health improvement and place the letter in the appropriate space. If "Nobody" use an X.

E = Excellent; G = Good; F = Fair; P = Poor; W = Worse; N = None

_____ Chiropractor _____ ER Physician _____ Massage Therapist _____ Neurologist
_____ Orthopedist _____ Physical Therapist _____ Primary Care Physician ____Surgeon
_____ Other _____ Nobody

9. How long have you had this problem? _____

10. How do you think your problem began? _____

11. Do you think this problem to be severe? _____ Yes _____Yes, at times _____ No

12. What aggravates your problem? _____

13. What makes your problem feel better? _____

14. What concerns you the most about your problem; what does it prevent you from doing?
_____

15. What is your: _____ Height _____Weight _____Age Occupation _____

16. How would you rate your overall health? ____Excellent ____Very Good ____Good ____Fair ____Poor

17. Do you do exercise? ____Regular ____Occasional ____Rarely _____Not at all If you do exercise, list what you do.

18. Indicate if you have any immediate family members with any of the following:

_____ Rheumatoid Arthritis _____Diabetes _____Lupus _____Heart Problems _____Cancer _____ALS

19. List all the prescription medications you are currently taking:

_____

20. List all the over-the-counter medications you are taking:

_____

21. List all the vitamins and dietary supplements you are taking: _____

21. List the kind and year of all surgical procedures you have undergone:

_____

_____

22. Have you ever been hospitalized? _____ YES _____ NO If YES list the kind and year of all admissions.

_____

_____

23. Have you had significant past trauma? _____ YES _____ NO If YES list the kind of trauma and the year.

_____

_____

24. What is your current occupation? _____

25. Check the activities do you do at work and circle the frequency of each activity:

_____ **Sitting** Most of the day Half the day A little of the day
_____ **Standing** Most of the day Half the day A little of the day
_____ **Walking** Most of the day Half the day A little of the day
_____ **Kneeling** Most of the day Half the day A little of the day
_____ **Lifting/Carrying** Most of the day Half the day A little of the day
_____ **Pushing** Most of the day Half the day A little of the day
_____ **Pulling** Most of the day Half the day A little of the day
_____ **Reaching** Most of the day Half the day A little of the day
_____ **Twisting** Most of the day Half the day A little of the day
_____ **Fine Manipulation** Most of the day Half the day A little of the day
_____ **Computer Use** Most of the day Half the day A little of the day
_____ **Grasping** Most of the day Half the day A little of the day
_____ **Hand Tool Use** Most of the day Half the day A little of the day
_____ **Machinery Controls** Most of the day Half the day A little of the day
_____ **Telephone** Most of the day Half the day A little of the day
_____ **Driving** Most of the day Half the day A little of the day
_____ **Other ( )** Most of the day Half the day A little of the day

Name: _____ Date: _____

SOCIAL HABITS: Alcohol ___#day ___ years; Tobacco ___#day ___#years; Caffeine ___#day ___#years; ___

Pain Meds ___#day ___ #years; ___Vitamins _____

ONGOING HEALTH HABITS: Weight Train Body Building Walk Run Swim Bicycle Mountain Biking Yoga Pilates Stretching Gymnastics Cross-Fit Martial Arts Basketball Football Baseball Softball Frisbee Canoe/Kayak Rock Climb Racquet Sports , Ski Downhill, Ski XC, Snowboarding, Scuba, Fishing, Card Games, Chess Other_____

Do you get regular (3-5 times per week) aerobic exercise? ____Yes ____ NO. If yes, what do you do? _____

In order to improve your spinal health and therefore your body's health, are you willing to do ongoing exercise at a sufficient level, frequency, and duration in order to create beneficial changes within your body? YES NO

What results do you want from your chiropractic treatment? _____

REVIEW OF SYSTEMS: COMPLETE ALL OF THE SECTIONS, IF "DENY" THEN CHECK "DENY"

CONSTITUTIONAL: "I DENY ANY CONSTITUTIONAL ISSUE(S)" ____

__Chills __Fatigue __Weight gain __Fever __Daytime Drowsiness __Night sweats__Weight loss

EYES/VISION: "I DENY ANY VISION ISSUE(S)" ____

__Blindness __Blurred vision__Eye pain __Field cuts (visual field defect) __Tearing

__Wear glasses/Contact lenses__Cataracts __Double vision __Photophobia

EARS, NOSE, AND THROAT: "I DENY ANY EARS, NOSE, AND THROAT ISSUE(S)" ____

__ Bleeding __Dizziness __Sinus infections__Headaches __Nasal congestion

__TMJ problems __Snoring __Dental Implants __Fainting __Ear drainage __Head Injury

__Loss of smell__Nose bleeds (frequent)__Sore throats (frequent)__Dentures

__Ear infections __Discharge__Hearing loss __Post nasal drip __Rhinorrhea (runny nose)

__Tinnitus (ringing in ears) __Difficulty swallowing __Ear pain __Vocal hoarseness

RESPIRATION: "I DENY ANY RESPIRATION ISSUE(S)" ____

__ Asthma __Cough__Coughing up blood __Shortness of breath __Painful breath

__Sputum production __Wheezing __Emphysema

Name: _____ Date: _____

<u>CARDIOVASCULAR</u>: "I DENY ANY CARDIOVASCULAR ISSUE(S)" ____

__Angina (chest pain) __Heart problems__Claudication (leg pain) __Heart murmur

__Heart problems __Swelling of legs __Orthopnea (difficulty breathing while lying down)

__Palpitations (irregular or forceful beating of heart) ___High Blood Pressure

__Paroxysmal nocturnal dyspnea (waking at night with shortness of breath)

__Shortness of breath with exertion or exercise __Ulcers __Varicose veins

<u>GASTROINTESTINAL</u>: "I DENY ANY GASTROINTESTINAL ISSUE(S)" ____

__Abdominal pain __Difficulty swallowing __Nausea __Abnormal stool __Belching

__ Heartburn __Rectal bleeding __Black, tarry stool __Hemorrhoids __Vomiting

__Constipation __Indigestion __Vomiting blood __Diarrhea __Jaundice (yellowing skin)

__Abnormal stool color

<u>FEMALE</u>: "I DENY ANY FEMALE ISSUE(S)" ____

__Birth control therapy __Breast lumps/pain __Burning urination __Cramps

__Frequent urination __Hormone therapy __Irregular menstruation __Urine retention

__Vaginal bleeding __Vaginal discharge

Are you pregnant? Yes/No: Date of last period _____

<u>MALE</u>: "I DENY ANY MALE ISSUE(S)" ____

__ Burning urination __Erectile dysfunction __Prostate problems __Urine retention

__Frequent urination __Hesitancy/Dribbling

<u>ENDOCRINE</u>: "I DENY ANY ENDOCRINE ISSUE(S)?" ____

__Cold intolerance __Frequent urination __Voice changes __diabetes __Goiter __ Excessive appetite

__Hair loss __Excessive hunger __Heat intolerance __Excessive thirst __Unusual hair growth

Name: _____ Date: _____

<u>SKIN</u> "I DENY ANY SKIN ISSUE(S)" ____

__Changes in nail texture __Changes in skin color__Hair growth __Hair loss __Hives

__Itching __Paresthesia (numbness, prickling or tingling) __Rash __History of skin disorder

__Skin lesions/Ulcers __Varicositites

<u>NERVOUS SYSTEM</u>: "I DENY ANY NERVOUS SYSTEM ISSUE(S)" ____

__Dizziness __Loss of memory __Stress __Facial weakness __Numbness __Strokes

__Headaches __Seizures __Tremors__Limb weakness __Sleep disturbances

__Unsteadiness of gait__Loss of consciousness __Slurred speech

<u>PSYCHOLOGIC</u>: "I DENY ANY PSYCHOLOGIC ISSUE(S)" ____

__Inability to experience pleasure from normally pleasurable acts __Bipolar disorder

__Mood changes __Confusion __Convulsions __Anxiety __Depression __Appetite changes

__Insomnia__Behavioral changes __Memory loss

<u>ALLERGY</u>: "I DENY ANY ALLERGY ISSUE(S)" ____

__Anaphylaxis (history of) __Food intolerance__Itching __Nasal congestion __Sneezing

<u>HEMATOLOGY</u>: "I DENY ANY HEMATOLOGIC ISSUE(S)" ____

__ Anemia __Bleeding __Blood clotting__Blood transfusion __Bruise easy __Fatigue

__Lymph node swelling

Anything else you want to say? YES NO. If YES, what? _____

_____

Patient Signature: _____ Date: _____