INTERNAL USE ONLY
Cash____ PI____ WC___
Provider_____
Ded_____ Co-Pay_____

New Patient Intake Form

Name_____ Date_____ Male ☐ Female ☐

Mailing Address_____ Apt/Ste_____

City_____ State_____ Zip Code_____

Cell Phone_____ Work Phone_____ Home Phone _____

Birth Date_____ Age_____ Social Security Number _____

Marital Status S ☐ M ☐ D ☐ W ☐ Number of Children____ Email_____

Occupation_____ Employer_____

Spouse Name_____ Spouse Employer_____

Name of Emergency Contact_____ Phone #_____

How do you prefer to be verbally addressed?_____ Text appointment reminders? Y ☐ N ☐

Whom may we thank for referring you?_____

Family Dr./Primary Care Physician_____

We normally keep your primary care physician updated on your care at our office, is this okay? Y ☐ N ☐

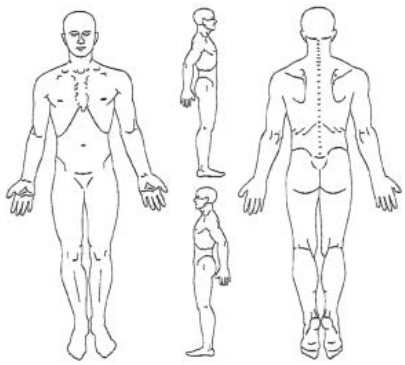
1) What is your present complaint?_____

_____

MARK ON THE PICTURES WHERE YOU HAVE PAIN OR OTHER SYMPTOMS INCLUDING NUMBNESS OR TINGLING.

Using the line below as a scale, please rate the pain you are experiencing NOW:

NO PAIN* 1 ---------- 10 *SEVERE PAIN



2) Specific date problem started?_____

3) How did your problem begin?_____

4) Do you experience any dizziness with your symptoms? Y ☐ N ☐

5) In the past have you experienced anything similar to this? Y ☐ N ☐

6) For your present complaint have you seen any other doctor? Y ☐ N ☐ If yes, whom?_____

What Treatment?_____

7) How intense is the pain? ☐ *Minimal* ☐ *Mild* ☐ *Moderate* ☐ *Severe/Excruciating*

8) Please describe the character of your current pain (check all that apply)

☐ *Sharp* ☐ *Burning* ☐ *Shooting* ☐ *Aches* ☐ *Soreness* ☐ *Numbness* ☐ *Dull* ☐ *Stiff* ☐ *Tingling* ☐ Other_____

9) How constant are the complaints present?

☐ *Occasional (25%)* ☐ *Intermittent (50%)* ☐ *Frequent (75%)* ☐ *Constant (100%)* ☐ Other_____

10) Is the pain: ☐ *Increasing* ☐ *Decreasing* ☐ *Not Changing* ☐ *Varies in Intensity*

11) Is the pain aggravated by: ☐ *Walking* ☐ *Sitting* ☐ *Standing* ☐ *Riding in car* ☐ *Lifting* ☐ *Bending*

☐ *Stretching* ☐ *Twisting* ☐ Other _____

12) The pain is reduced by: ☐ *Medicine* ☐ *Exercise* ☐ *Rest* ☐ *Adjustments* ☐ *Therapy*

☐ Other_____

13) What would you like to do, but can't, because of the pain? _____

14) Are your complaints affecting your ability to work or be active?

☐ *No effect* ☐ *Some Physical Restrictions* ☐ *Unable to Perform Regular Duties*

15) Any fever or chills? Y ☐ N ☐

16) Are your complaints affecting your ability to sleep? Y ☐ N ☐

17) Any changes in bowel or bladder (bathroom) function? Y ☐ N ☐

18) Have you missed any days of work or school? Y ☐ N ☐ Dates missed_____

19) Please list any allergies (drug or other) _____

20) Have you broken any bones? Y ☐ N ☐ Please explain_____

21) Have you been in the hospital or had surgery for any reason? Y ☐ N ☐ Please explain _____

_____

22) Have you ever been in a major car accident? Y ☐ N ☐ Please explain _____

_____

23) What prescription medication or drugs are you taking?_____

☐ *Anti-inflammatory* ☐ *Pain Killers* ☐ *Muscle Relaxers* ☐ *Blood Pressure* ☐ *Insulin* ☐ *Birth Control*

☐ *Tranquilizers* ☐ *Diet Pills* ☐ *Nerve Pills* ☐ Other_____

24) What non-prescription meds are you taking?

☐ *Tylenol* ☐ *Ibuprofen* ☐ *Aspirin* ☐ Other_____

25) Do you smoke? Y ☐ N ☐ How much?_____

26) Do you drink? Y ☐ N ☐ How much?_____

27) What is your exercise routine?_____

28) Other health concerns?_____

_____

29) What do you hope to achieve from this visit? Check all that apply.

☐ *Pain relief* ☐ *Explanation of your condition* ☐ *Education/exercises to prevent recurrence*

30) Are you seeking ☐ *Lasting corrective care* ☐ *Temporary relief*

31) Do you have insurance? Y ☐ N ☐ Name of Insurance Co. _____