Michael J. Dutton, D.C. • Brian D. Herren, D.C.
1765 State Street C Salem, Oregon 97301 • (503) 763-3528

Patient Intake Questionnaire

Full name: _____ Today's date: _____
Date of birth: _____ Social security number: _____ Driver's license #: _____
Home address: _____ City: _____ State: ____ Zip: _____
Home phone:_____Cell Phone_____Marital status:_____ Number of dependents: ____
Your occupation: _____ Employer: _____ Work phone #: _____
Work address: _____ City: _____ State: ____ Zip: _____

Spouse, parent, or guardian's name: _____ Relationship:_____
Their address: _____ Their phone #: _____
Who referred you to our office?_____

Current Symptoms

List the present symptom(s) you are having: _____
_____
_____
_____
_____
_____
_____

Have you ever had a similar problem before? ☐ Yes ☐ No When? _____
Please explain in detail when and how your symptoms began: _____
_____
_____
What have you done to get relief?_____
_____
Have you had previous treatment for this? ☐ Yes ☐ No
If yes, when?_____ By whom? _____
What was done? _____
_____

Current Pain Level

Please rate your pain severity on a scale of 0-10, with 0 being pain-free, and 10 the worst pain you have ever experienced.
How is your pain right now?

0	1	2	3	4	5	6	7	8	9	10
NONE	MILD Noticeable Pain, Minimal loss of motion.			MODERATE Moderate Pain that may cause Some degree of disability. Significant loss of motion.				SEVERE Severe Pain, Marked or total loss of motion.		

How high and low does your pain go? (circle 2 numbers)

0	1	2	3	4	5	6	7	8	9	10
NONE	MILD Noticeable Pain, Minimal loss of motion.			MODERATE Moderate Pain that may cause Some degree of disability. Significant loss of motion.				SEVERE Severe Pain, Marked or total loss of motion.		

What makes your condition worse?

☐ Lifting ☐ Standing from seated position ☐ Nothing
☐ Walking ☐ Sitting ☐ Inactivity
☐ Exercise ☐ Standing ☐ Movement
☐ Home activities ☐ Work activities ☐ Other_____

What makes your condition better?

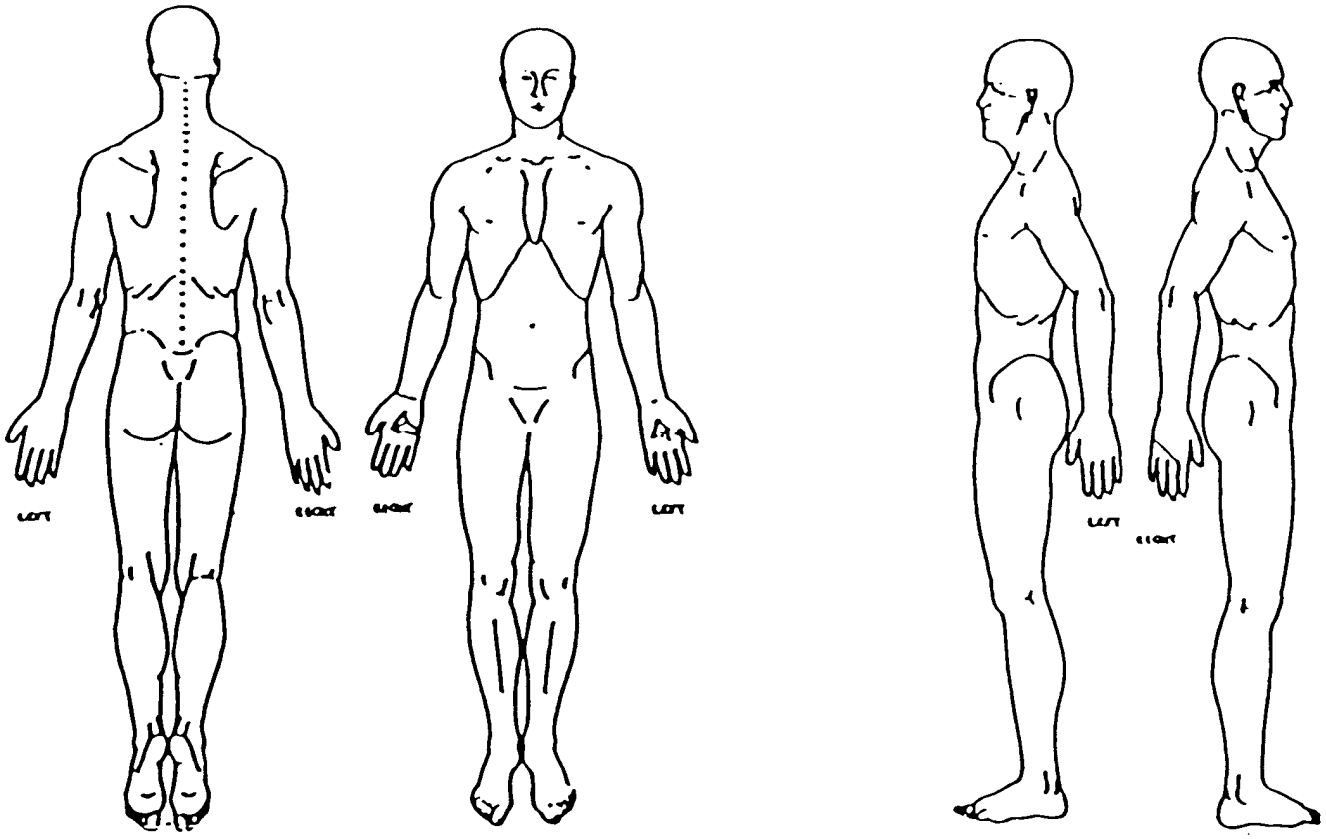
☐ Standing ☐ Exercise ☐ Physical Therapy
☐ Sitting ☐ Movement ☐ Pain Medication
☐ Sleep ☐ Walking ☐ Anti-inflammatories
☐ Lying down ☐ Inactivity ☐ Massage
☐ Stretching ☐ Hot shower/bath ☐ Nothing ☐ Other____

Check symptoms associated with your current problem:

☐ Headache ☐ Dizziness ☐ Sleeping problems ☐ Chest pain
☐ Neck pain/stiffness ☐ Fainting ☐ Numb feet/toes ☐ Nervousness
☐ Mid-back pain ☐ Ringing in ear ☐ Numb hands/fingers ☐ Eyes sensitive to light
☐ Low back pain ☐ Loss of balance ☐ Loss of concentration ☐ Unexplained weight change
☐ Loss of smell ☐ Pain behind eyes ☐ Loss of taste ☐ Weakness
☐ Depression ☐ Loss of memory ☐ Digestive disorders

Current Pain Level (continued)

Please mark your areas of pain on the figures below.
Shade and code area(s) of complaint: use codes: P = pain; N = numb; S = spasm
If these symptoms are spreading to other areas, please use arrows to show where and in what direction.



Do you have, or have you had, any of the following?

☐ Dizziness	☐ Asthma	☐ Headaches	☐ Digestive disorders
☐ Anemia	☐ Sinus trouble	☐ Numbness	☐ High blood pressure
☐ Heart trouble	☐ Heartburn	☐ Tuberculosis	☐ Loss of consciousness
☐ Diabetes	☐ Stroke	☐ Cancer	

Past History

Have you had any past significant injuries? (list with approximate year) _____

_____

_____

Have you been involved in any past motor vehicle accidents? ☐ Yes ☐ No When? _____

_____

If yes, were you injured? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

What significant illnesses have you had? _____

_____

Have you had any surgeries? (list with approximate year) _____

_____

What medications are you currently using? _____

_____

Mark any family illnesses: ☐ diabetes ☐ stroke ☐ cancer ☐ heart disease ☐ list all others _____

_____

Do you have a primary care physician? ☐ Yes ☐ No If yes, who? _____

Have you received previous chiropractic care? ☐ Yes ☐ No If yes, by whom? _____

For what condition?

Is there anything else that you think the doctor should know? _____

_____

Billing Information

It is important that we have complete and correct billing information so that we can expedite your claim

PRIMARY HEALTH INSURANCE

Referral#_____Co-Pay$_____Effective Date_____To_____

Insured Name_____Date of birth_____SSN/ID#_____

Insurance Carrier_____Insurance phone_____

Group#_____Employer_____

Insurance coverage for chiropractic? ☐ Yes ☐ No

SECONDARY HEALTH INSURANCE

Insured's Name_____Date of Birth_____SSN/ID#_____

Insurance Carrier_____Relationship to patient_____

Insurance phone_____Employer_____Group#_____

Payment is due at the time of service, unless other arrangements have been made. Patients involved in litigation (law suits) or third party payment are ultimately responsible for payment for services.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE ABOVE AND AGREE TO ABIDE BY SAME.

Patient signature: _____ Date:_____

Guardian signature: _____ Date: _____