

**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
<b>NONE</b>	<b>MILD</b> Noticeable Pain, Minimal loss of motion.			<b>MODERATE</b> Moderate Pain that may cause Some degree of disability. Significant loss of motion.				<b>SEVERE</b> 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
<b>NONE</b>	<b>MILD</b> Noticeable Pain, Minimal loss of motion.			<b>MODERATE</b> Moderate Pain that may cause Some degree of disability. Significant loss of motion.				<b>SEVERE</b> Severe Pain, Marked or total loss of motion.		

What makes your condition worse?

- Lifting
- Walking
- Exercise
- Home activities
- Standing from seated position
- Sitting
- Standing
- Work activities
- Nothing
- Inactivity
- Movement
- Other\_\_\_\_\_

What makes your condition better?

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

Check symptoms associated with your current problem:

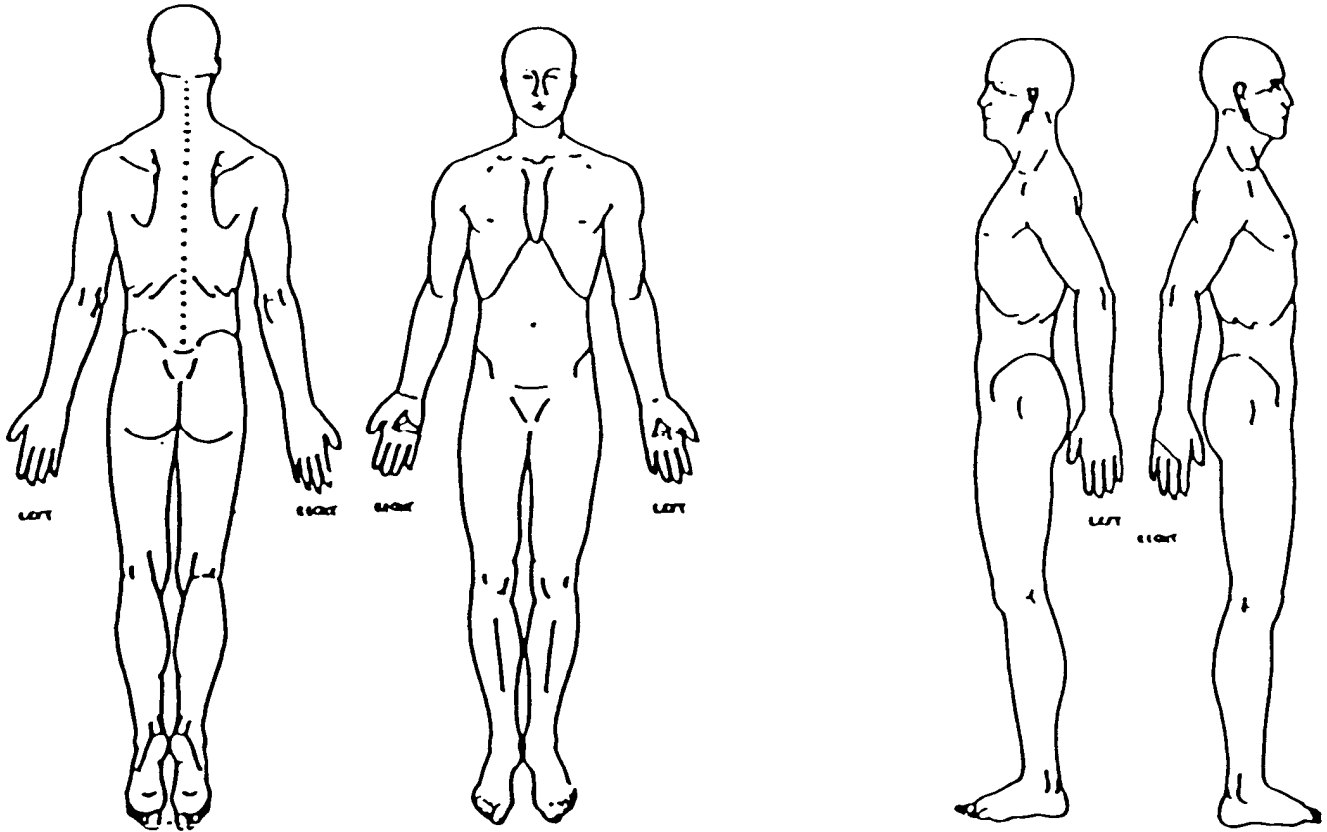
- Headache
- Neck pain/stiffness
- Mid-back pain
- Low back pain
- Loss of smell
- Depression
- Dizziness
- Fainting
- Ringing in ear
- Loss of balance
- Pain behind eyes
- Loss of memory
- Sleeping problems
- Numb feet/toes
- Numb hands/fingers
- Loss of concentration
- Loss of taste
- Digestive disorders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

**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?

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Dizziness     | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Headaches    | <input type="checkbox"/> Digestive disorders   |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Numbness     | <input type="checkbox"/> High blood pressure   |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Heartburn     | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Stroke        | <input type="checkbox"/> 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? \_\_\_\_\_

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## **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: \_\_\_\_\_