Intake History

Date: _____

Name: _____ DOB: _____

Referring Provider: _____ Primary Care Provider: _____

Reason for your visit (Chief Complaint): _____

Onset of current symptoms: (please circle)
Acute Injury Gradual Over Time Worker's-Compensation Auto Collision Other_____

Describe your current symptoms: _____

- Location (where on your body): _____
- Quality (words that describe the pain): _____
- Average Severity (0-10 scale, 10 is worst pain imaginable): _____
- Duration (how long have you been experiencing the pain): _____
- Timing (e.g. constant, intermittent, at night, with activity): _____
- What makes the pain better: _____
- What makes it worse: _____
- Progression: Worsening Unchanging Improving Changing _____
- Associated symptoms: _____
- Is there litigation surrounding this case [Yes / No] Attorney's name: _____

Please indicate the current severity of your pain by placing a mark on the pain rating scale:

No Pain 0	1	2	3	4	5	6	7	8	9	10 Worst Pain

Indicate what treatments you have already tried for your current problem: (please circle)

☐ Physical Therapy ☐ Chiropractic ☐ Massage ☐ Acupuncture
☐ Biofeedback ☐ Psychological Counseling Injections Surgery

Other treatments: _____

What diagnostic tests have you had performed for this problem: (please circle)

CT EMG MRI X-RAYS Other: _____

Medical History: Please list medical problems you have been treated for (such as diabetes or asthma).

Alcoholism	CVA (Stroke / Brain Hemorrhage)	Liver Disease
Anemia	Dementia/Alzheimer's	Migraine
Arrhythmia (Irregular Heart Beat)	Degenerative Disc Disease	Multiple Sclerosis
Arthritis	Degenerative Joint Disease	Nephrolithiasis (Kidney Stones)
Asthma	Diabetes Type I	Obesity
Atrial Fibrillation	Diabetes Type II	Osteoarthritis
Bronchitis	Emphysema	Osteoporosis
Coronary Artery (Heart) Disease	Epilepsy	Prior MI (Heart Attack)
Cancer (type) _____	Fracture	Pulmonary Disease
Cardiovascular Disease	Gastro-Esophageal Reflux Disease	Rheumatoid Arthritis
Congestive Heart Failure	Glaucoma	Seizures
Crohn's Disease	Hepatitis	Sickle Cell Disease
Cirrhosis	High Cholesterol	Sexually Transmitted Disease
Colitis	Hyperlipidemia	Thyroid Disease
Constipation	Implanted Medical Device	TIA (Mini-Stroke)
COPD (Lung Disease)	Kidney Disease	Tuberculosis
Chronic Renal Failure	Ulcers	Valve Problems

_____

_____

_____

Surgical History: Please include the approximate dates of these surgeries

No Prior Surgeries	Mastectomy	Total Knee Replacement
Appendectomy	Shoulder Surgery	Total Hip Replacement
D&C	Spinal Surgery	Tubal Ligation
Hysterectomy	Tonsillectomy	
Knee Arthroscopy		

_____

_____

Medications: Please include prescriptions, over-the-counter medications, and supplements
** Include pain medications even if only taken as needed **

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug Allergies: Please list drug/class and type of reaction _____

_____

Family History: Indicate if family members have pertinent medical problems: (M=mother, F=father, S=sibling)

Ankylosing Spondylitis	Colitis	Kidney Disease
Arthritis	COPD	Liver Disease
Alcoholism	Crohn's Disease	Osteoarthritis
Anemia	CVA/TIA (Stroke)	Osteoporosis
Anxiety	Depression	Psoriasis
Asthma	Diabetes	Pulmonary Disease
Bleeding Disorder	Epilepsy	Renal Disease
CAD (Heart Disease)	GERD	Rheumatoid Arthritis
MI (Heart Attack)	Gout	SLE (Lupus)
Cancer	Hypertension	Thyroid
Other:		

Do any of your family members have a history of substance abuse or alcoholism [Yes / No]

Social History:

Smoking Status:

Never a smoker
Current everyday smoker
Current some day smoker
Former smoker - year quit smoking: _____
Smoked for how long: _____

Alcohol use: None Occaisional Moderate Heavy Quit

Illicit Drug Use: Yes/No _____

Marijuana use: Yes/No _____

Occupation: Work full-time Work part-time Unemployed
On Disability Retired Student
Occupation: _____

Preventive Care: last complete physical examination with your Primary Care Provider _____

What specific activies do you hope to regain the ability to participate in via treatment through our practice? (Your Functional Goals)

_____

_____

Do you currently have any of the following problems? (please circle if present) Items not circled are not present

Constitutional:
- Activity changes
- Chills
- Fevers
- Unexpected weight changes

HENT:
- Ear pain
- Hearing loss
- Sinus pain
- Difficulty swallowing

Eyes:
- Eye discharge
- Eye pain
- Vision changes

Respiratory:
- Chest tightness
- Cough
- Shortness of Breath
- Wheezing

Cardiovascular:
- Chest Pain
- Swelling of the Legs
- Palpitations

Gastrointestinal:
- Abdominal pain
- Constipation
- Diarrhea
- Vomiting

Endocrine:
- Cold Intolerance
- Heat Intolerance
- Excessive thirst

Genitourinary:
- Painful urination
- Incontinence
- Flank pain
- Urgency

Musculoskeletal:
- Joint Pain
- Problems walking
- Joint swelling

Neurological:
- Dizziness
- Headaches
- Numbness
- Weakness

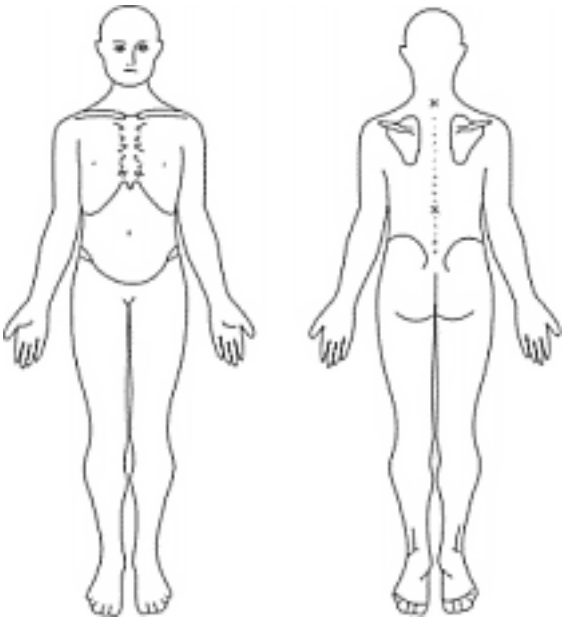
Hematologic:
- Painful lymph nodes
- Bruising or bleeding easily

Psychiatric:
- Confusion
- Anxiety
- Sleep Disturbance
- Depression

Other:

Please diagram the location and nature of your pain

Aching ^^^	Burning XX	Numbness ---
Stabbing / / /	Pins/Needles …	Shooting → →



Patient Signature: _____