

PATIENT INTAKE FORM

ALL INFORMATION IS CONFIDENTIAL



Patient Name: _____
(Last) (First) (MI)

Date: _____ How were you referred to us? _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

What type of case is responsible for today's problem? ☐ Workman's Compensation ☐ Auto Accident ☐ Personal Insurance ☐ Other

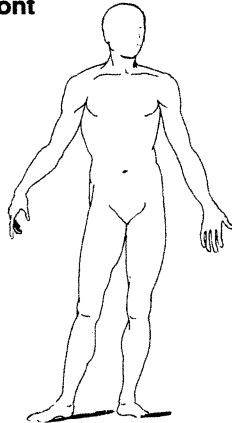
Are you personally insured? ☐ Yes ☐ No Are we going to be billing your personal Insurance? ☐ Yes ☐ No

Insurance Company: _____

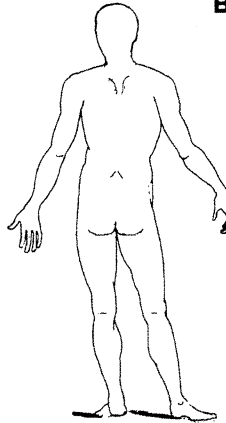
Policy ID: _____ Group No.: _____

Indicate on the drawings below where you have pain/symptoms:

Front



Back



You will have to answer questions about each of the different areas indicated on the above figures.

NECK

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time) ☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain?

- ☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse
☐ Sharp with motion ☐ Achy ☐ Shooting with motion ☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion ☐ Stiff ☐ Other: _____

How are your symptoms changing with time?

- ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

How much has the problem interfered with your work?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problem?

- ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER physician ☐ Orthopedist
☐ Massage Therapist ☐ Physical Therapist ☐ Other: _____ ☐ No one

How long have you had this problem? _____

How do you think your problem began? _____

Do you consider this problem to be severe?

- ☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

- ☐ Bending ☐ Sleeping ☐ While at Work ☐ Driving a Car ☐ Climbing Stairs
☐ Working at a computer ☐ Flexing and extending ☐ Standing Up ☐ Golfing ☐ Stress
☐ Playing Tennis ☐ Traveling ☐ Running ☐ Walking ☐ Sitting
☐ Other: _____

What alleviates your problem? _____

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

Mid Back

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time) ☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain?

- ☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse
☐ Sharp with motion ☐ Achy ☐ Shooting with motion ☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion ☐ Stiff ☐ Other: _____

How are your symptoms changing with time?

- ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

How much has the problem interfered with your work?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problem?

- ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER physician ☐ Orthopedist
☐ Massage Therapist ☐ Physical Therapist ☐ Other: _____ ☐ No one

How long have you had this problem?

How do you think your problem began?

Do you consider this problem to be severe?

- ☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

- ☐ Bending ☐ Sleeping ☐ While at Work ☐ Driving a Car ☐ Climbing Stairs
☐ Working at a computer ☐ Flexing and extending ☐ Standing Up ☐ Golfing ☐ Stress
☐ Playing Tennis ☐ Traveling ☐ Running ☐ Walking ☐ Sitting
☐ Other: _____

What alleviates your problem?

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

Low Back

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time) ☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain?

- ☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse
☐ Sharp with motion ☐ Achy ☐ Shooting with motion ☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion ☐ Stiff ☐ Other: _____

How are your symptoms changing with time?

- ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

How much has the problem interfered with your work?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

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Who else have you seen for your problem?

- ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER physician ☐ Orthopedist
☐ Massage Therapist ☐ Physical Therapist ☐ Other: _____ ☐ No one

How long have you had this problem?

How do you think your problem began?

Do you consider this problem to be severe?

- ☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

- ☐ Bending ☐ Sleeping ☐ While at Work ☐ Driving a Car ☐ Climbing Stairs
☐ Working at a computer ☐ Flexing and extending ☐ Standing Up ☐ Golfing ☐ Stress
☐ Playing Tennis ☐ Traveling ☐ Running ☐ Walking ☐ Sitting
☐ Other: _____

What alleviates your problem?

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

FILMS

On the Job Injury (Worker's Compensation)

Employer Name: _____ Employer Address: _____
Contact Person: _____ Date Injured: _____ Hour of Injury: _____ a.m./p.m.
Who is your Worker's Compensation carrier? _____ Claim No.: _____
Name of Adjuster: _____ Phone No.: _____ Extn: _____
Where are you hurting as a result of your current injury? _____
How did your injury occur? _____
Where were you working when you were injured (Location)? _____
Did you require post-accident hospitalization? ☐ No ☐ Yes If yes, name of hospital: _____
Have you lost any days of work? ☐ No ☐ Yes Dates: _____ Date last worked: _____
Did you report this injury to your foreman or employer? ☐ No ☐ Yes
Do you have an attorney that has advised you in this case? ☐ No ☐ Yes
Attorney's name: _____ Address: _____ Phone: _____

Personal Injury (Auto Collision/Other) Essential Information

Date of accident: _____ Hour: _____ a.m./p.m.
Name of the Insurance Company covering the vehicle that you were a passenger/driver in: _____
Adjuster: _____ Claim No.: _____
Address: _____ Phone: _____ Extn: _____
Have they authorized payment for medical/chiropractic expenses? ☐ No ☐ Yes
Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ No ☐ Yes
Did your injuries occur in the course of employment ("on the job")? ☐ No ☐ Yes
Where are you hurting as a result of your current injury? _____
How did your injury occur? _____
Have you lost any days of work? ☐ No ☐ Yes Dates: _____ Date last worked: _____
Was a police report filled out? ☐ No ☐ Yes
Do you have an attorney that has advised you in this case? ☐ No ☐ Yes
Attorney's name: _____ Address: _____ Phone: _____

Auto Collision

Location of accident: _____
Name of insurance company covering the other vehicle: _____ Claim No. _____
To help us better understand the effects of the accident on your body (spine), please complete the following questions:
Were you: ☐ Driver ☐ Passenger ☐ Pedestrian
Were you struck from: ☐ Behind ☐ Right side ☐ Left side ☐ Front ☐ Auto was parked
Did your car strike the other (s) involved? ☐ No ☐ Yes OR Did the other car strike yours? ☐ No ☐ Yes
Was your car stationary at the time of impact? ☐ No ☐ Yes
If no, approximately how fast was your car going? ☐ Under 5 mph ☐ 10-20 mph ☐ 25-40 mph ☐ Over 40 mph
Was the other car stationary at the time of impact? ☐ No ☐ Yes
If no, approximately how fast was their car going? ☐ Under 5 mph ☐ 10-20 mph ☐ 25-40 mph ☐ Over 40 mph
Were you aware or unaware of the impending impact? ☐ No ☐ Yes
Were you wearing a seatbelt? ☐ No ☐ Yes
Did the airbags deploy? ☐ No ☐ Yes
Did your head hit the headrest upon impact? ☐ No ☐ Yes
Did you require post-accident hospitalization? ☐ No ☐ Yes If yes, name of hospital: _____
Was any other person injured? _____
Anything bizarre happen? (like glasses jerked off face, etc.) _____
Name of the owner of other vehicle (if more than one vehicle was involved) _____
