Patient Intake Form

Name:____ Date:__________

IN THE SPACE BELOW TELL ME WHAT IS GOING ON. TELL ME WHERE IT HURTS AND WHAT HAPPENED!!

CIRCLE: NECK MIDDLE BACK LOW BACK EXTREMITY OTHER ______________

____

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____

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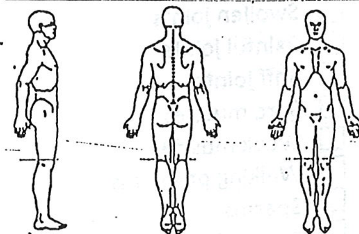
WHEN DID IT HAPPEN? Date/place ______________________________



MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

Onset: __ acute __ gradual __ chronic __unknown

Cause: __ accident __ injury __unknown __other

Prior pain in the area: __No __Yes __years ago __on and off or years

Side: __left __ right __both

CHANGE IN CONDITION: __ getting worse __ getting better __ not changing

Since __ condition began __ last week __ last month

***Use N for neck, M for middle back and L for low back

Quality of pain: __ achy __ burning __dull __ sharp __ stiff __ throbbing __ sharp @ times __ weak __ numb __ shooting __ gripping __ tingling __sore

****HOW OFTEN DOES THE PAIN BOTHER YOU***? __ **constantly**(all day) __ **frequently**(most of day) __ **intermittently**(some of day) __**occasionally**(off and on)

****WHEN IS IT WORSE***? ___unchanged ___morning ___as day goes on ___ afternoon ___ evening ___ during the night

What makes it worse? __nothing __driving __lifting __movement __resting __sleeping __sitting __ standing __walking __working __bending __twisting __inactivity

****WHEN IS IT BETTER***? ___unchanged ___morning ___as day goes on ___afternoon ___evening ___ during the night

What makes it better? __ nothing __cold __chiropractic care __massage __medications __movement __ rest __sleep __walking __ warmth __inactivity.

Does it hurt going from sitting to standing? ___Y ___N

Does it hurt getting in and out of bed? __Y __N Do you need help? __Y __N

Does it hurt going up and down steps? __Y __N Do you need railing or support? __Y __N

What activities are you kept from doing? ______________________________