New Patient Intake

Today's Date: _____ **Who Referred You**?_____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

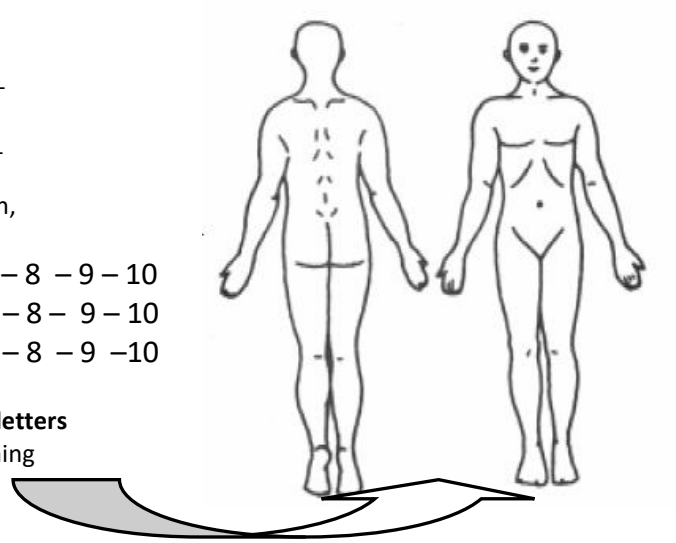
E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Occupation: _____ Employer Name/Company:_____Work Phone:_____

Marital Status: ❑ Single ❑ Married Emergency Contact:_____ Phone:_____

Do you have Insurance: ❑ Yes ❑ No Do you have kids under 18? ❑Yes ❑ No

Please identify your top 3 SYMPTOMS:
Primary: _____
Second: _____
Third: _____



On a scale of **1** to **10** with **10** being the **worst pain** and zero being no pain, rate your above complaints **on average** by ***circling the number*:**

Primary or chief complaint is : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 –10

PLEASE MARK the areas on the Diagram to the right with the following **letters** to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

Please CHECK all symptoms you have ever had, even if they seem minimal or do not seem to be related to your current problem.

☐ Headaches/Migraines	☐ Neck Pain/Stiff	☐ Gastrointestinal	☐ Hormonal Problems
☐ Numbness/Tingling	☐ Upper Back Pain/Stiff	☐ Lower Back Pain/Stiff	☐ Irritable/Depression
☐ Dizziness/Balance	☐ Middle Back/Stiff	☐ Fatigue/Low Energy	☐ Sleeping Problems

List any past surgeries or write NONE on the line provided: _____

Please CHECK all symptoms or diseases that apply to your **family's history**.

☐ Headaches/Migraines	☐ Neck Pain/Stiff	☐ High Blood Pressure	☐ Diabetes
☐ Numbness/Tingling	☐ Upper Back Pain/Stiff	☐ Lower Back Pain/Stiff	☐ Irritable/Depression
☐ Dizziness/Balance	☐ Middle Back/Stiff	☐ Heart Disease	☐ Cancer

Please CIRCLE YES or **NO** to all that apply to your current/past **social history**

Smoking: **YES/NO** Alcohol: **YES/NO** (# drinks per week: _____) Exercise: **YES/NO** (# days per week: _____)

Please list any medications/drugs you are currently taking: _____

_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPPA policy at the front desk. Please sign to indicate you have been made aware of its availability. These statements made on this form are accurate to the best of my recollection and I agree to let this office examine me further for evaluation. I am not currently pregnant and agree to any recommended x-rays.

Patient Signature or Legal Guardian: _____Date:_____

Examiner Signature (I have reviewed front and back of this document): _____ Date: _____

Functional Rating Index

For use with your primary Neck and/or Back Problems. If your primary problem is not related to either area, please fill it out as it relates to your primary problem. In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now

1. Pain Intensity					
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain	
2. Sleeping					
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep	
3. Personal Care (washing, dressing, etc.)					
No pain no restriction	Mild pain no restriction	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance	
4. Travel (driving, etc.)					
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips	
5. Work					
,Can do , usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work	
6. Recreation					
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible pain	
7. Frequency of Pain/Discomfort					
No pain	Occasional pain 25% of the day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day	
8. Lifting					
No pain w/heavy weight	Increased pain w/ heavy weight	Increased pain w/ moderate weight	Increased pain w/ light weight	Increased pain w/ any weight	
9. Walking					
No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain after all walking	
10. Standing					
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain w/ any standing	

Name _____
PRINTED

_____ _____
SIGNATURE DATE

_____
Total Score (filled in by staff)