☐ **New Patient Core Priority** ☐ **Re-activation Intake** **Last X-ray:** _____ **Last Adjustment:** _____

Name: _____ **ID#:**_____ **Ref:** _____ **Date:** _____ CA GI MC PI WC

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, details: Past DC _____ Last Adj _____ Frequency _____
Satisfied/Helped _____ Type of care _____ Reason for discontinued care _____

Positive: _____

Negative: _____

Problems/complaints/symptoms that <u>BROUGHT PATIENT IN</u> (On Intake Form): ☐ Neck pain ☐ Upper back pain ☐ Mid back pain ☐ Low back pain
☐ Hip pain L R ☐ Sciatica L R ☐ Shoulder L R ☐ Wrist L R ☐ Knee L R ☐ Ankle L R ☐ Headaches/Migraines
☐ Other _____

How did your condition develop? (Did it come on gradually from an activity, event, or injury?) DOI/DOL: _____

_____

_____

_____

_____

When was the first time in your life you ever had the same or similar problem? Please Explain. _____

_____

How many times have you experienced it since the first time it happened? _____

Is the frequency, intensity or length of time the condition lasts getting ☐ **worse** or the ☐ **same**? Please Explain. _____

_____

When it is at its worst, describe how it feels? ☐ Sharp ☐ Stabbing ☐ Dull Ache ☐ Deep Ache ☐ Burning ☐ Limited & painful ☐ Numbness/tingling
☐ Annoyance ☐ Weak ☐ Heavy feeling ☐ Throbbing ☐ Debilitating ☐ Other _____

NAME: **ID#:** **DATE:**

Symptoms/health condition identified by patient <u>RELATED TO THEIR SPINAL REGION OF PAIN AND DISCOVERED DURING INTAKE</u> :

☐ Neck pain	☐ Upper back pain	☐ Middle back pain	☐ Lower back pain
☐ Headaches/Migraines	☐ Shoulder pain L R	☐ Chest Pain/Short of breath	☐ Diarrhea/Constipation/Excess Gas
☐ Dizziness	☐ Pn,Numb,Ting,Wk to Arms/Hands/fngrs	☐ Heart Palpitation/Murmur	☐ Frequent Urination/Urinary Inf.
☐ Sinuses/Allergies/ Ear Inf.	☐ Cold/Burning to Hands	☐ Stomach/Digestive Problems	☐ Pain/numb/ting/weak down legs
☐ Ringing/Buzzing Ears	☐ Thyroid Condition	☐ Heartburn/ Indigestion	☐ Cramping in Legs/Toes/Feet
☐ Pain Behind Eyes/Blurred Vision	☐ Fatigue/Insomnia	☐ Ulcers/Acid Reflux	☐ Cold/Burning/Swelling Feet
☐ Sore Throat/Throat Infections	☐ Asthma/Upper Resp. Inf.	☐ Sciatica L R/Hip pain L R	☐ Cramping/Irregular Periods
□ Other _____			☐ Difficult Getting Pregnant/Impotence

Core Problems/ Complaints/Symptoms: **#1** _____ **#2** _____ **#3** _____

#4 _____ **#5** _____ **#6** _____

When your pain (Core 1,2,3,4,5,6) is at its worse how does it affect or interfere with your normal activities of daily living? Such as ……

( ) Self Care: has your condition/pain interfered with your ability to take care of yourself: your ability to dress, shower, drive the car, fall or stay asleep?

_____

_____

( ) Mental State: has your condition/pain affected your ability to/or cause: ☐concentrate/focus ☐ depression ☐ anxiety ☐ anger ☐ lack of motivation ☐ stress ☐ fatigue ☐ frustration ☐ irritability ☐ Other _____

( ) Recreation: has your condition/pain limited your ability to participate in hobbies, sports, physical fitness, or other leisure time activities? _____

_____

( ) Work or School: has your condition/pain made you less effective or productive at work or school? If yes, has it caused you to miss any days at school, work, or affected your income yet?

_____

( ) Family/Home Responsibilities: Has this limited your ability to do house chores, yard work, grocery shop, caring/playing with the children, or your relationship with your spouse? _____

_____

Patient's #1 Goal/Priority: _____