

Patient Intake Questionnaire

Date: _____

Name: _____ DOB: _____ Height: _____ Weight: _____

Referring Physician: _____

Please describe your main problem: _____

When did it begin? _____ Is it getting **(circle one)**: better / worse / staying the same

What prior treatment have you received (chiropractic, massage, etc.)? _____

What makes it worse? _____

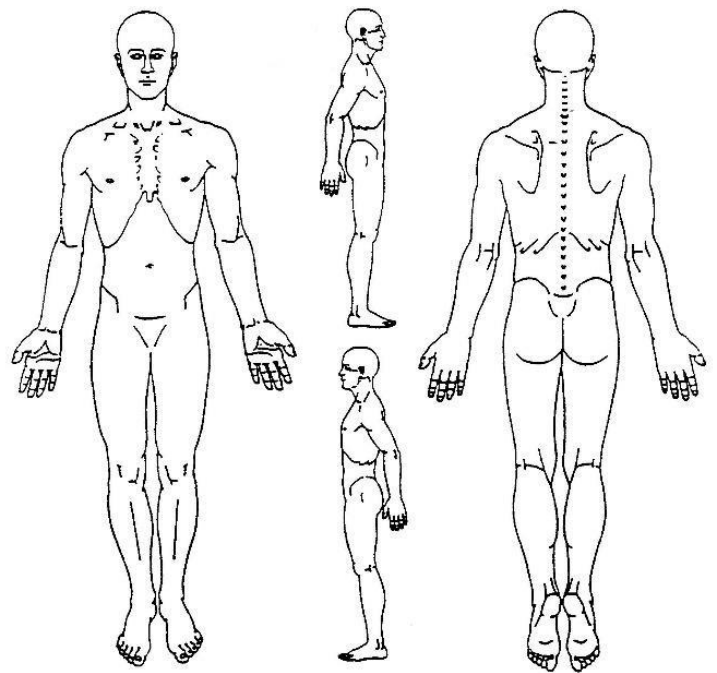
What makes it better? _____

Medical History:

Do you have or have you had the following:

	Yes	No
Cancer		
Diabetes		
Osteoarthritis		
Rheumatoid Arthritis		
Osteoporosis		
Headaches		
Ringin in Ears		
Hypoglycemia		
High Blood Pressure		
Heart Disease		
Pacemaker		
Lung Disease		
Neurological Condition (MS, Parkinson's, CVA/Stroke)		
Thyroid Condition		
Dizziness/Fainting		
Fevers/Chills		
Unexplained Weight Changes		
Bowel/Bladder Issues		
Urine Leakage		
Pelvic Pain		
Other Conditions		

Please indicate below where your symptoms are located:



KEY: numbness: =====
pins & needles: 0000
stabbing pain: /////
burning pain: XXXX

Pain level (0-10, 0=no pain, 10=worst pain):

Current: _____ / 10

At best: _____ / 10

At worst: _____ / 10

If you answered yes to any of the above, please explain:



Do you have any allergies? Y / N

Please explain: _____

Surgical History:

Spine:	Y / N	Date: _____	Hysterectomy:	Y / N	Date: _____
Shoulder:	Y / N	Date: _____	C-Section:	Y / N	Date: _____
Knee:	Y / N	Date: _____	Prostatectomy:	Y / N	Date: _____
Hip:	Y / N	Date: _____	Appendectomy:	Y / N	Date: _____
Ankle:	Y / N	Date: _____	Gall Bladder:	Y / N	Date: _____
Laparoscopy:	Y / N	Date: _____	Hernia repair:	Y / N	Date: _____

Other surgeries: _____ Any upcoming surgeries/procedures? Y / N

Are you currently taking any medication/supplements (prescription or over-the-counter)? Yes____ No____
If yes, please list medications:

Medication name:	Dosage/ frequency	Route (i.e.: oral, cream)

Have you had any falls in the past 12 months? (circle one) Yes / No
If yes, how many? _____ Were you injured in the fall(s)? (circle one) Yes / No

What activities/exercise do you currently participate in? (running, swimming, yoga, golf, etc)

Which activities or tasks would you like to be able to perform that you can't currently do because of your current concern?

Any additional comments or concerns not addressed in this questionnaire?

