

Intake Sheet & Progress Form

Today's Date ___/___/___ Date of Injury ___/___/___ New Injury? - Auto or Work Injury Yes - No -

Name _____ Insurance Company 1st _____ 2nd _____

On the figures below, please mark the areas where you feel pain or discomfort. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops.

Symbols to use

Ache: >>>

Numb: ===

Pins/Needles: 000

Burning: XXX

Stabbing: ///

Throbbing: ~~~

Age _____

Height _____

Weight _____

For returning patients;
is there anything new?

Please Explain _____

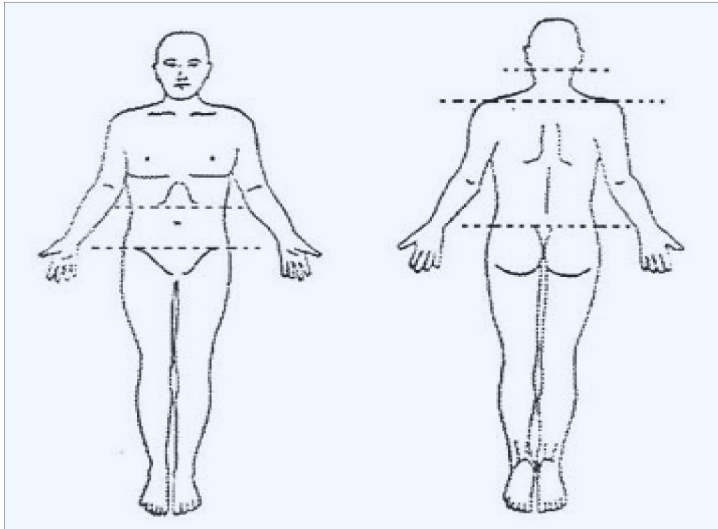
Any re-injuries that have
prolonged your recovery?

Joint replacement surgery?

Yes - No -

Left___ Right ___

Knee Hip Shoulder Other _____



Are symptoms worse?

Morning

Mid Day

Evening

With Movement

What decreases the symptoms?

Chiropractic

Ice

Heat

Massage

Medications

Movement

Rest

Please place an X (or a range of X's) on the line below representing any pain or symptoms you are experiencing today.

Pain Free |-----| Worst Pain Possible

Please place an X on this line to represent the highest level of pain or other symptoms since your last visit?

Pain Free |-----| Worst Pain Possible

Please place an X on this line to rate your ability to function at your job.

Complete Function |-----| No Function

How much has pain or other symptoms limited your daily activities?

No Interference |-----| Unable to do any activities

Which daily activities are limited? _____

In the past week, have your symptoms been present: 0-25% 26-50% 51-75% 76-100% of the time?

Is there anything else you would like to add about your treatment here, or which has impacted your progress?

Please explain _____

Signature: _____ Thank You!

Initial Health Status

Date ___/___/___

Name _____ Patient # _____ New Injury? _____

The following information will help us treat you in the most thorough and complete way. Please fill out this form completely and bring anything that concerns you to our attention.

Please check all of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Recent fever | <input type="checkbox"/> Currently pregnant (due date ___/___/___) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Marked morning pain/stiffness |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pain unrelieved by position or rest |
| <input type="checkbox"/> Head injuries or concussion(s) | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Corticosteroid use | <input type="checkbox"/> Epilepsy/seizures |
| <input type="checkbox"/> Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss | <input type="checkbox"/> Weakness in legs or arms |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Sleeping troubles |
| <input type="checkbox"/> Dizziness/fainting/loss of balance | <input type="checkbox"/> Fatigue, low energy, or depression |
| <input type="checkbox"/> Numbness in groin/buttocks | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cancer or tumors | <input type="checkbox"/> Frequent colds or illnesses |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tension/irritability |
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Medications – Ask for Supplement Form |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Other health problems (explain) _____ | _____ |

Problems with: eyes - ears - nose - throat - asthma - chronic cough -

Heart: stent - bypass - angioplasty - history of angina - arrhythmia - heart surgery - other -

Digestive: reflux irritable bowel - GERD - colonectomy - other gastric surgery - other -

Family history of: cancer - diabetes - heart problems - cholesterol - Other - _____

Children: ages ___ ___ ___ boys - girls - both - Do your kids receive regular chiropractic care? ___

Exercise: yes - no - cardio - weights - gym member - home workouts - walking - _____

Alcohol: none - mild - moderate - heavy - smoker - How many packs per day? _____

Are you under stress at work or at home? - Do you participate in any stress reduction activities such as:
Meditation - massage - yoga - or creative visualization - other _____

How long has it been since you felt REALLY healthy? _____ On a scale of 0 to 100, where 0 is nearly dead and 100 is optimum health, what number is your health today? _____ Where would you like to be? _____

I certify to the best of knowledge, the above information is complete and accurate. I agree to notify the clinic and my chiropractor immediately whenever I have changes in my health condition(s). I understand that my chiropractor may need to contact my other physician(s) if my condition needs to be co-managed, therefore I give authorization to my chiropractor to contact my other physician(s), as necessary.

Patient Signature _____ Date ___/___/___