SPINAL HEALTH AND REHAB CENTER

INTAKE HISTORY

Today's Date: _____

General Patient Information

Name: _____ DOB: _____ Phone Number: (____) -_____ - _____

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

Place of Employment: _____ Occupation: _____

Marital Status (please circle): Single Married Divorced Spouse Name: _____ Children? (please circle) Yes No

Were you referred to our office by anyone? (please circle) Yes No If yes, please print name: _____

Emergency Contact:

Name: _____ Phone number: (____) -_____ - _____ Relationship to you: _____

General Health Information

Primary Care Physician: _____ Phone Number: _____

Please list any significant accidents, surgeries or illnesses that you have had or currently have and any dates, if possible:_____

_____

Do you take any medications? Please list:_____

_____

Physical activities—please list any activities you take part in and how frequently:

_____

_____

Are you currently seeking treatment for general health maintenance or a specific injury? _____

Have you ever seen a chiropractor in the past? (Please Circle) Yes No If so, what for? _____

Do you currently use a heel lift/orthotic/arch support? (Please circle) Yes No

Current Symptoms

Chief Complaint (s): _____

Is this from a work related injury/ car accident? (Please circle) Yes No

** If the answer is yes, please contact the front desk about whether personal injury paperwork is necessary

Date that symptom(s) began: _____ Did any specific event lead to symptom onset? If so, please describe:

_____

_____

Please list any other doctors, as well as their specialty, you have seen regarding this complaint: _____

Please list any testing you have had regarding this complaint (X-ray, MRI, CT Scans, etc): _____

Pain:

Pain Severity (0= No pain, 10= Worst Pain: Your Average: _____ At your Worst: _____

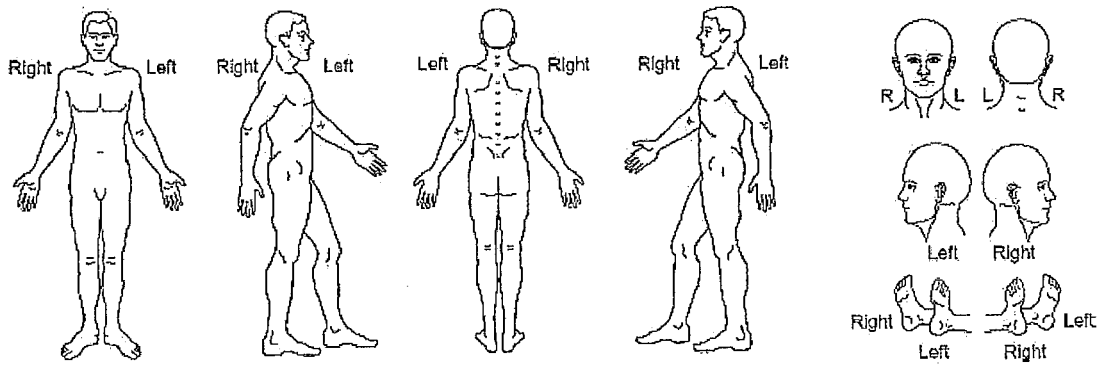
Is the pain worse during a particular activity or at a certain time of the day? (Please circle) Yes No If yes, please describe:

_____

_____

Does this pain radiate anywhere? (Please circle) Yes No If yes, where? _____

Using the diagram below, please identify areas of pain:



Please check the following as it pertains to you:

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Pain in the upper arm
- ☐ Hand pain
- ☐ Wrist pain
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Pain in upper leg/hip
- ☐ Pain in lower leg/knee
- ☐ Ankle or foot pain
- ☐ Jaw pain
- ☐ Fainting
- ☐ Visual disturbances
- ☐ Seizures
- ☐ Dizziness
- ☐ Headache
- ☐ Muscular incoordination
- ☐ Ringing in the ears (tinnitus)
- ☐ Rapid heart rate/ Atrial Fibrillation
- ☐ Chest pain
- ☐ Loss of appetite
- ☐ Anorexia
- ☐ Abnormal weight gain or loss
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Chronic cough
- ☐ Chronic sinusitis
- ☐ General fatigue
- ☐ Irregular menstrual flow
- ☐ Breast soreness/lumps
- ☐ Endometriosis
- ☐ PMS
- ☐ Incontinence
- ☐ Painful or frequent urination
- ☐ Abdominal pain
- ☐ Constipation/irregular bowels
- ☐ Difficulty swallowing
- ☐ Heart burn/GERD/ Indigestion
- ☐ Rash/Hives
- ☐ Depression
- ☐ Aortic Aneurysm
- ☐ High blood pressure
- ☐ Angina
- ☐ Heart attack
- ☐ Stroke
- ☐ Asthma
- ☐ Cancer
- ☐ Tumors
- ☐ Prostate problems
- ☐ Blood disorders
- ☐ Arthritis/ rheumatoid arthritis
- ☐ Diabetes
- ☐ Ulcers
- ☐ Liver/gallbladder problems
- ☐ Kidney Stones
- ☐ Hepatitis
- ☐ Bladder infection
- ☐ Colitis
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ HIV/AIDS
- ☐ Systemic Lupus

*Please check all that apply:

- ☐ Tobacco
- ☐ Alcohol
- ☐ Drug/Alcohol Dependence
- ☐ Caffeine # cups/day ____