

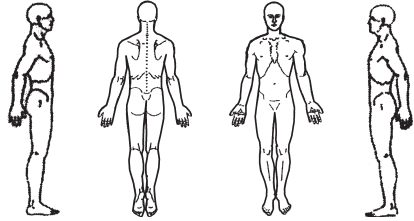


SALAMA CHIROPRACTIC CENTER

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Patient Intake Form

1. Indicate with an X on the drawings below where you have pain/symptoms. Please list/Describe your symptoms in order of Severity



1. _____
2. _____
3. _____
4. _____
5. _____

2. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

3. How would you describe the type of pain?

- Sharp Tingly Numb Sharp with motion
 Diffuse Shooting Stiff Shooting with motion
 Dull Achy Burning Stabbing with motion
 Electric like with motion Other _____

4. How are your symptoms changing with time.

- Getting Worse Not Changing Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please Circle)

6. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

7. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

8. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER Physician Orthopedist Other _____
 Massage Therapist Physical Therapist No One

9. How long have you had this problem? _____

10. How do you think your problem began?

11. Do you consider this problem to be severe?

- Yes Yes, at times No

12. What aggravates your problem?

13. What makes your problem better?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____

Occupation _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

(PLEASE TURN OVER)

18. Indicate if you have any Immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
- Heart Problems Cancer ALS

19. What treatment have you already received for your condition? Medications Surgery Physical Therapy

- Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | | | | | |
|--------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine | | | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexually Transmitted | | |
| Anorexia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's | | | Tumors, Growths | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood | | | Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical | | | Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Poilo | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____ | | |
| Chicken Pox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | | |

20. What habits do you currently do?

- Smoking Packs/Day _____ Alcohol Drinks/Week _____
- Coffee/Caffeine Drinks Cups/Day _____ High Stress Level Reason _____

21. Are you pregnant? Yes No Due Date _____

22. List all prescription medications/supplements you are currently taking:

23. List all of the over-the-counter medications you are currently taking:

24. List all surgical procedures you have had:

25. What activities do you do at work?

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |

26. What activities do you do outside of work?

27. Have you ever been hospitalized? No Yes

If yes, why _____

28. Have you ever seen a chiropractor? No Yes

If yes, what was your experience? _____

29. Have you had significant past trauma? No Yes

30. Anything else pertinent to your visit today? _____

Print Patient Name _____ DOB: _____

Patient Signature _____ Date: _____