Osborne
Chiropractic Clinic

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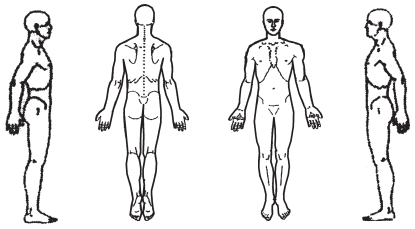
Patient Intake Form

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

3. How would you describe the type of pain?
   - ❑ Sharp
   - ❑ Diffuse
   - ❑ Dull
   - ❑ Electric like with motion
   - ❑ Tingly
   - ❑ Shooting
   - ❑ Achy
   - ❑ Numb
   - ❑ Stiff
   - ❑ Burning
   - ❑ Other _____
   - ❑ Sharp with motion
   - ❑ Shooting with motion
   - ❑ Stabbing with motion

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
   - ❑ ER Physician
   - ❑ Massage Therapist
   - ❑ Neurologist
   - ❑ Orthopedist
   - ❑ Physical Therapist
   - ❑ Primary Care Physician
   - ❑ Other _____
   - ❑ 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	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Rheumatoid Arthritis	❑ Yes	❑ No
Alcoholism	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	Measles	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Allergy Shots	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Migraine			Scarlet Fever	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Fractures	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Sexually Transmitted		
Anorexia	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Miscarriage	❑ Yes	❑ No	Disease	❑ Yes	❑ No
Appendicitis	❑ Yes	❑ No	Goiter	❑ Yes	❑ No	Mononucleosis	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Gonorrhea	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No	Suicide Attempt	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Mumps	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Bleeding Disorders	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Breast Lump	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Bronchitis	❑ Yes	❑ No	Hernia	❑ Yes	❑ No	Parkinson's			Tumors, Growths	❑ Yes	❑ No
Bulimia	❑ Yes	❑ No	Herniated Disk	❑ Yes	❑ No	Disease	❑ Yes	❑ No	Typhoid Fever	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Pinched Nerve	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	High Blood			Pneumonia	❑ Yes	❑ No	Vaginal Infections	❑ Yes	❑ No
Chemical			Pressure	❑ Yes	❑ No	Polio	❑ Yes	❑ No	Whooping Cough	❑ Yes	❑ No
Dependency	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Prosthesis	❑ Yes	❑ No	Other _____		
Chicken Pox	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ 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?
    - ❑ Sit: ❑ Most of the day ❑ Half the day ❑ A little of the day
    - ❑ Stand: ❑ Most of the day ❑ Half the day ❑ A little of the day
    - ❑ Computer work: ❑ Most of the day ❑ Half the day ❑ A little of the day
    - ❑ On the phone: ❑ Most of the day ❑ Half the day ❑ 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: _____