HUG Chiropractic Clinic
We get to the core of the problem

3153 Cahaba Heights Road
Birmingham Alabama **35243**
205.967.0280
www.birminghamchiropractor.net

CONFIDENTIAL PATIENT INTAKE FORM

NAME: _____AGE:_____DOB:_____SS#_____

HOME ADDRESS: _____CITY:_____ST:_____ZIP_____

EMPLOYER:_____OCCUPATION:_____E-MAIL_____@_____

HOME TEL: _____PAGER/CELL_____WORK TEL: _____FAX:_____

EMERGENCY CONTACT: _____TEL:_____PHYSICIAN:_____

☐SINGLE ☐MARRIED ☐DIVORCED ☐ WIDOWED ☐SIGNIFICANT OTHER # CHILDREN_____

SPOUSE: _____DOB:_____TEL:_____SS#:_____

EMERGENCY CONTACT: _____TEL:_____PHYSICIAN:_____

REFERRED BY: DR._____ PATIENT: _____ OTHER: _____

HEALTH INSURANCE: ☐NO ☐YES:_____

YOU ARE *CURRENTLY* EXPERIENCING: ☐BACK PAIN ☐NECK PAIN ☐HEADACHE ☐OTHER_____

DESCRIBE☐:_____

THIS HAPPENED *WHEN?* _____ *WHERE?* ☐HOME ☐WORK ☐CAR WRECK ☐OTHER_____

THIS HAPPENED *HOW?* _____

HAVE YOU HAD THIS OR SIMILAR HAPPEN BEFORE? _____

WHAT MAKES THE PROBLEM BETTER? _____

WHAT MAKE THE PROBLEM WORSE? ☐SITTING ☐STANDING ☐LYING ☐MOVEMENT ☐REST
☐USE ☐WALKING ☐RUNNING ☐WORKING ☐ACTIVITY
☐BENDING ☐LIFTING ☐TWISTING ☐OTHER_____

DESCRIBE THE PAIN OR SENSATION: ☐ACHY ☐BURNING ☐DULL ☐NUMB ☐SHARP
☐SHOOTING ☐SORE ☐STABBING ☐STIFF ☐TINGLING

DOES THE PAIN RADIATE TO ANOTHER AREA OF THE BODY? ☐NO ☐YES - *WHERE*? _____

HOW FREQUENT IS THE PROBLEM? ☐CONSTANT ☐FREQUENT ☐INTERMITTENT ☐OCCASIONAL ☐ON/OFF
☐EVENING ONLY ☐MORNING ONLY ☐WORSE IN THE: ☐AM or ☐PM

WHAT % OF THE DAY DO YOU EXPERIENCE THIS PROBLEM? ☐0-25% ☐26-50% ☐51-75% ☐76-100%

OTHER DR.S SEEN FOR THIS CONDITION: ☐ NO ☐YES:_____WHEN? _____

PAST CHIROPRACTIC CARE: ☐NO ☐YES DRS NAME: _____WHEN? _____

CONSENT

I consent to any physical examination, x-ray study, laboratory procedures, chiropractic or adjunctive therapy or clinic service that is ordered under the general and specific instructions of the doctor(s).

PATIENT SIGNATURE: _____ DATE_____

GUARDIAN SIGNATURE: _____ DATE_____rev.08.09.07

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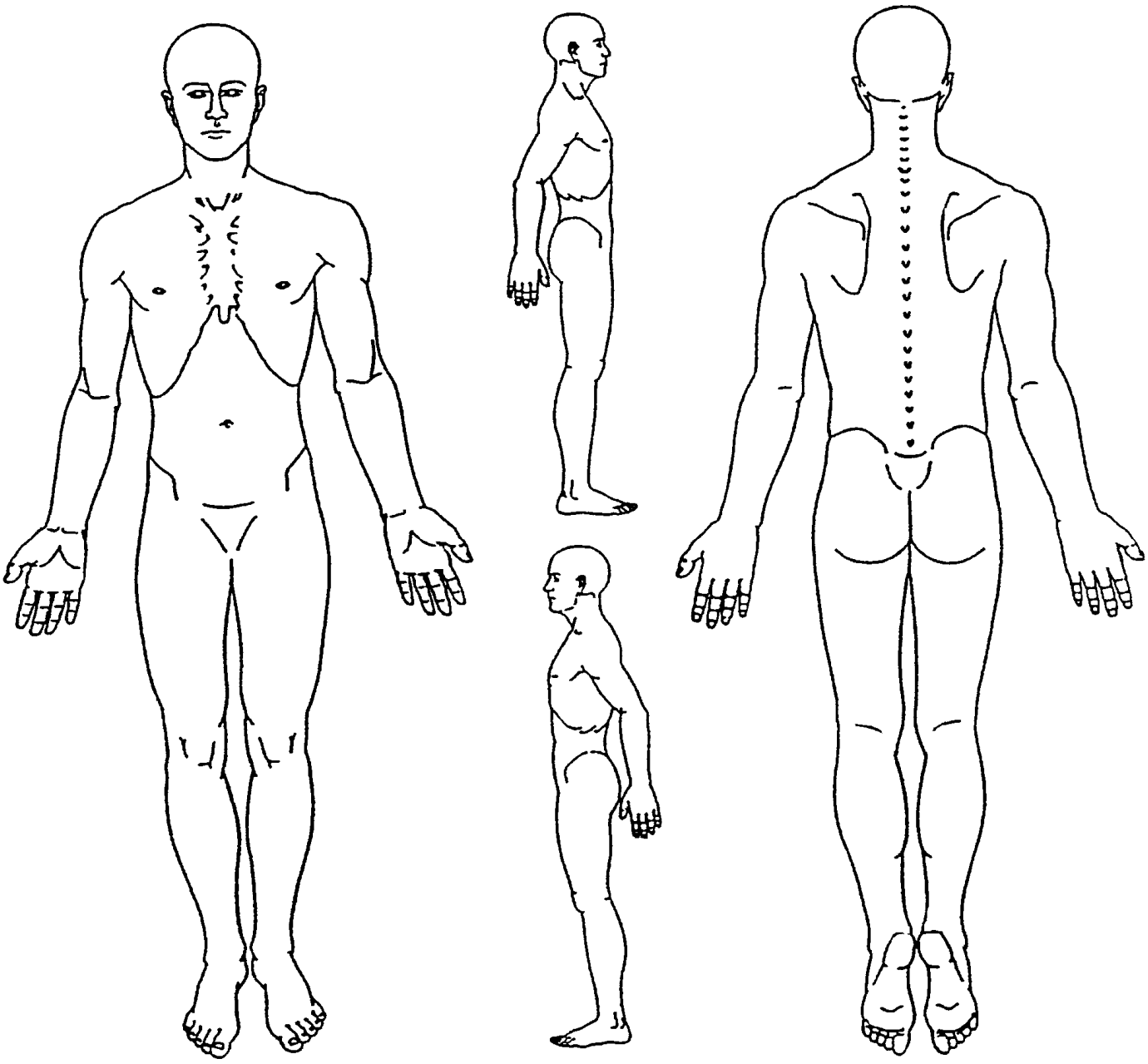
PAIN DRAWING

On the diagrams below please mark where you are experiencing your symptoms.

X = PAIN / DISCOMFORT
O = NUMBNESS / TINGLING



Patient Signature:_____ Date:_____

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REVIEW OF SYSTEMS AND HISTORY

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Check or circle the appropriate response, please leave blank if it does not apply.

Past Medical and/or Family History

(P=patient, M=mom, F=father, S=Sibling)

☐ Heart Disease	P M F S
☐ Asthma	P M F S
☐ Cancer	P M F S
☐ Arthritis	P M F S
☐ Headaches	P M F S
☐ Diabetes	P M F S
☐ MVP	P M F S
☐ Emphysema	P M F S
☐ Anemia	P M F S
☐ Fibromyalgia	P M F S
☐ Hernia	P M F S
☐ High BP	P M F S
☐ Low BP	P M F S
☐ Alzheimers	P M F S
☐ Alcoholism	P M F S
☐ Colitis	P M F S
☐ Epilepsy	P M F S
☐ Goiter	P M F S
☐ Gout	P M F S
☐ High Cholesterol	P M F S
☐ Kidney Disease	P M F S
☐ Leukemia	P M F S
☐ Lupus	P M F S
☐ Mental Condition	P M F S
☐ Obesity	P M F S
☐ Rheumatoid Arth.	P M F S
☐ Ulcers	P M F S
☐ Injuries	P M F S
☐ Trauma auto/etc.	P M F S
☐ Other	P M F S

Surgical History

☐ Appendectomy ☐ Hemorrhoid
☐ Gall Bladder ☐ Tonsillectomy
☐ Thyroidectomy ☐ Kidney Stone
☐ Bladder ☐ Endoscopy
☐ Angioplasty ☐ Heart Bypass
☐ Back/Neck Surgery
☐ Arthroscopic_____
☐ Joint Replacement_____
☐ Fracture_____
☐ Cancer Biopsy_____
☐ Other_____
☐ Other_____
☐ Other_____

Social History

Caffeine: ☐ No ☐ Light ☐ Heavy
Tobacco: ☐ No ☐ Yes
Packs Per day_____
Alcohol: ☐ No ☐ Yes
_____per day/week
☐ No work ☐ Part time
☐ Full Time ☐ School
☐ Retired ☐ Disability

Exercise

☐ Frequently
☐ Occasionally
☐ Rarely

Review Of Systems

Please circle if you have had any problems in any of the following:
(P=Past, 1=Mild, 2=Moderate, 3=Severe)

General Health

P 1 2 3 Fatigue/Tiredness
P 1 2 3 Fever/Night Sweats
P 1 2 3 Trouble Sleeping
P 1 2 3 Skin Irritation/Rash
P 1 2 3 Bleeding Disorder
P 1 2 3 Depression
P 1 2 3 Anxiety/Tension/Stress

EENT

P 1 2 3 Vision/Eye
P 1 2 3 Hearing/Ear
P 1 2 3 Throat/Swallowing
P 1 2 3 Nasal/Sinus
P 1 2 3 Headaches/Face Pain

Cardiopulmonary

P 1 2 3 Breathing
P 1 2 3 Swelling/Edema
P 1 2 3 Chest Pain

GI

P 1 2 3 Stomach/Abdominal
P 1 2 3 Diarrhea/Constipation
P 1 2 3 Vomiting/Nausea
P 1 2 3 Reflux/Indigestion

GU

P 1 2 3 Urinary Frequency/Urgency
P 1 2 3 Urinary/Burning/Discoloration
P 1 2 3 Sexual/Reproductive

Skeletal

P 1 2 3 Morning Stiffness
P 1 2 3 Night Pain
P 1 2 3 Neck Pain
P 1 2 3 Back Pain
P 1 2 3 Joint Pain_____

NeuroMuscular

P 1 2 3 Muscle Pain
P 1 2 3 Weakness
P 1 2 3 Numbness/Tingling
P 1 2 3 Tremors/Shakes
P 1 2 3 Loss of Consciousness
P 1 2 3 Passing out

Females

Pregnant: ☐Yes ☐No ☐I Don=t Know
☐ Last Menstrual Cycle_____
☐ Endometriosis ☐ Hysterectomy
☐ Tubaligation ☐ C-Section
☐ Breast Implants ☐ Breast Biopsy
☐ Mastectomy

Males

☐ Prostate problems

Present Medication

☐None ☐List_____
_____
_____
_____

Allergies

☐ Penicillin ☐ Codeine
☐ Aspirin ☐ Sulfa
☐ Other_____
☐ Other_____

Patient Name: _____Date:_____

Reviewer: _____Date:_____

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HEADACHE DISABILITY INDEX

Part 1INSTRUCTIONS: Please check the appropriate box for questions 1 and 2:
1. I have headache: ☐1 per month ☐more than but less than 4 per month ☐more than one per week.
2. My headache is: ☐mild ☐moderate ☐severe

Part 2 INSTRUCTIONS: ***PLEASE READ CAREFULLY:*** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

	yes	sometimes	no
E1. Because of my headaches I feel handicapped.			
F2. Because of my headaches I feel restricted in performing my routine daily activities.			
E3. No one understands the effect my headaches have on my life.			
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.			
E5. My headaches make me angry.			
E6. Sometimes I feel that I am going to lose control because of my headaches			
F7. Because of my headaches I am less likely to socialize.			
E8. My family and friends have no idea what I am going through because of my headaches.			
E9. My headaches are so bad that I feel I am going to go insane.			
E10. My outlook on the world is affected by my headaches.			
E11. I am afraid to go outside when I feel a headache is starting.			
E12. I feel desperate because of my headaches.			
F13. I am concerned about penalties at work or at home because of my headaches			
E14. My headaches place stress on my relationships with family or friends.			
F15. I avoid being around people when I have a headache.			
F16. I believe my headaches are making it difficult for me to achieve my goals in life.			
F17. I am unable to think clearly because of my headaches.			
F18. I get tense (e.g. muscle tension) because of my headaches.			
F19. I do not enjoy social gatherings because of my headaches.			
E20. I feel irritable because of my headaches.			
F21. I avoid traveling because of my headaches.			
E22. My headaches make me feel confused.			
E23. My headaches make me feel frustrated.			
F24. I find it difficult to read because of my headaches.			
F25. I find it difficult to focus my attention away from my headaches and on other things.			

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837842

OFFICE USE ONLY: Scoring
Total:____; E____; F____
(100) (52) (48)

Patient Signature: _____ Today's Date: _____/_____/_____