HUG CHIROPRACTIC CLINIC

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CONFIDENTIAL PATIENT INTAKE FORM

NAME:_______________ AGE:______ DOB:_______________ SS#_______________

HOME ADDRESS:_______________ CITY:_______________ ST:_________ ZIP_____________

EMPLOYER:_______________ OCCUPATION:_______________ E-MAIL_______________

HOME TEL: _______________ PAGER/CELL:_______________ WORK TEL: _______________ FAX:_______________

PREFERRED METHOD OF CONTACT: ☐HOME TEL ☐CELL TEL ☐WORK TEL ☐EMAIL

EMERGENCY CONTACT:_______________ RELATIONSHIP_______________ TEL:_______________

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐SIGNIFICANT OTHER ☐DIVORCED ☐WIDOWED # CHILDREN______

RACE: ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐BLACK OR AFRICAN AMERICAN
☐NATIVE OR OTHER PACIFIC ISLANDER ☐WHITE ☐PATIENT DECLINED TO PROVIDE

ETHNICITY: ☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATINO ☐PATIENT DECLINED TO PROVIDE

PRIMARY CARE PHYSICIAN:_______________ PHYSICIAN PHONE: _______________

REFERRED BY: DR._______________ PATIENT: _______________ OTHER_______________

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? _______________

PATIENT SIGNATURE: _______________ DATE_______________

GUARDIAN SIGNATURE: _______________ DATE_______________

REVIEW OF SYSTEMS AND HISTORY

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

Past Medical and/or Family History

P = patient M = mother,
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 Surgery ☐Neck Surgery
- ☐ Arthroscopic_____________________
- ☐ Joint Replacement________________
- ☐ Mastectomy ☐ Breast Implants
- ☐ Tubaligation ☐ C-Section
- ☐ Endometriosis ☐ Hysterectomy
- ☐ Other__________________________
- ☐ Other__________________________

Social History

Caffeine: ☐ No ☐ Light ☐ Heavy
Tobacco: ☐ No ☐ Yes
Packs Per day________
Alcohol: ☐ No ☐ Yes
_____________per day/week

Work History

- ☐ No work ☐ Part time
- ☐ Full Time ☐ School
- ☐ Retired ☐ Disability

Exercise

- ☐ Frequently
- ☐ Occasionally
- ☐ Rarely/Never

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

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_________________
- ☐ Fracture________________________

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__________

Males

☐ Prostate problems

Present Medication

☐None ☐List_________________________
____
____
____
____

Allergies

- ☐ Penicillin ☐ Codeine
- ☐ Aspirin ☐ Sulfa
- ☐ Other____________________________
- ☐ Other___________________________

Patient Signature____Date_____________________
Reviewer____Date______________

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PAIN DRAWING

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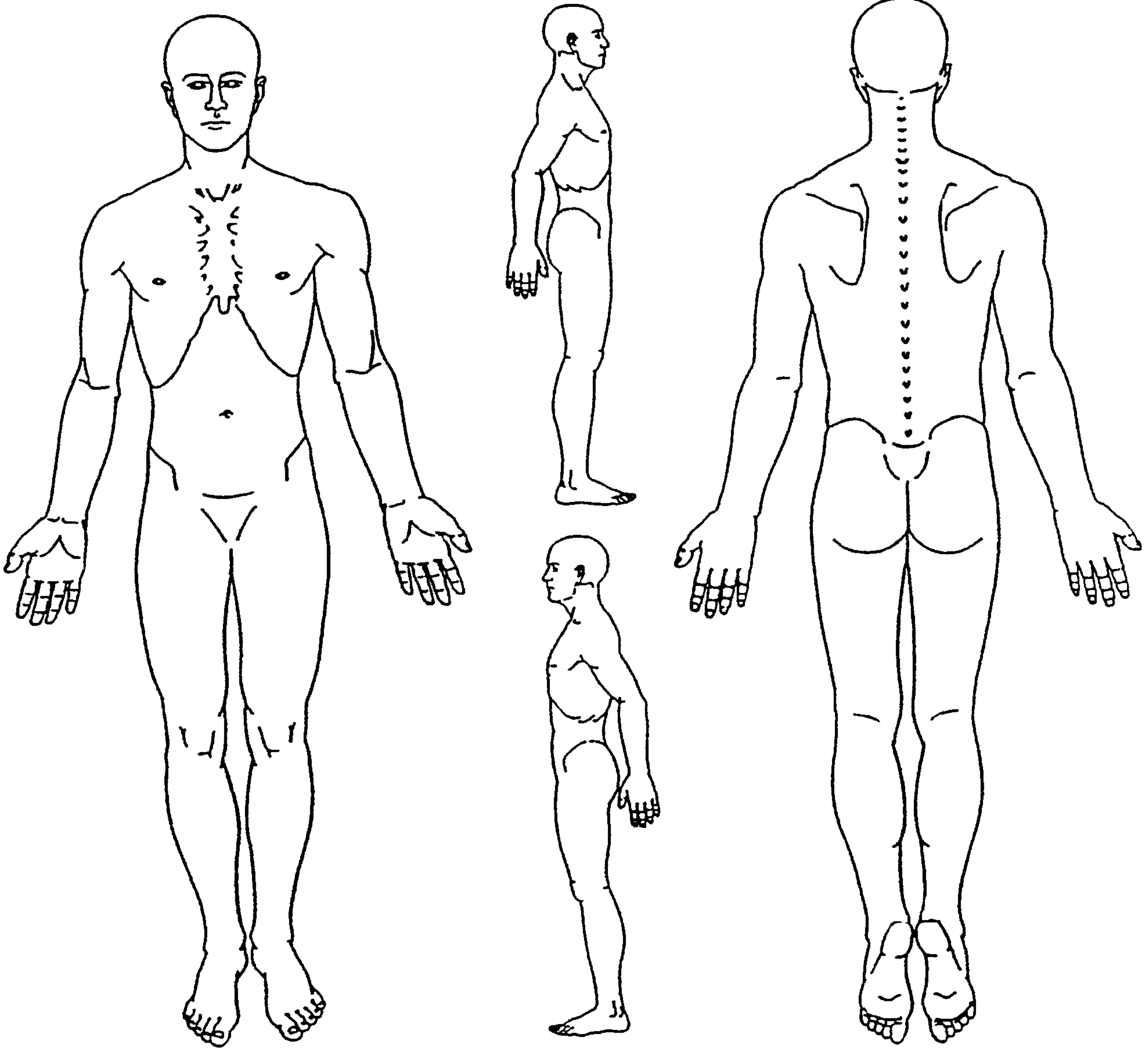
On the diagrams below please mark where you are experiencing your symptoms.

X = PAIN / DISCOMFORT
O = NUMBNESS / TINGLING



Patient Signature:____ Date:_______________________ rev 03.27.2014

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NECK PAIN AND DISABILITY QUESTIONNAIRE (Vernon-Mior)

Please read instructions: *This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life.* ***Please check the ONE ITEM in each section*** *which most closely applies to you.*

Section 1 - Pain intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight neck pain
- ☐ I can read as much as I want with moderate neck pain
- ☐ I can't read as much as I want because of moderate neck pain
- ☐ I can hardly read at all because of severe neck pain
- ☐ I cannot read at all

Section 5 - Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 - Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating
- ☐ I have a lot of difficulty in concentrating
- ☐ I have great difficulty in concentrating
- ☐ I cannot concentrate at all.

Section 7 - Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 - Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all

Section 9 - Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed.(2-3 hours sleepless)
- ☐ My sleep is greatly disturbed.(3-5 hours sleepless)
- ☐ My sleep is completely disturbed.(5-7 hours sleepless)

Section 10 - Recreation
- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I can't do any recreation activities at all.

PAIN SEVERITY SCALE: Rate the severity of your pain by checking one box on the following scale:

0	1	2	3	4	5	6	7	8	9	10

No Pain **Excruciating Pain**

Signature:____Date:____________________ rev.03.27.2014