Medical Intake Form - Please complete all information as accurately as possible:

Name ____ Age ____________

What town do you live in? ____

Who is your primary care doctor? ____________________________________ City________________________

Who is your chiropractor? ____ City________________________

Who is your physical therapist? ____________________________________ City________________________

Who is you massage therapist/acupuncturist? ________________________ City________________________

1. Please list your most concerning reasons for your visit, in order of importance to you:

   a. ____

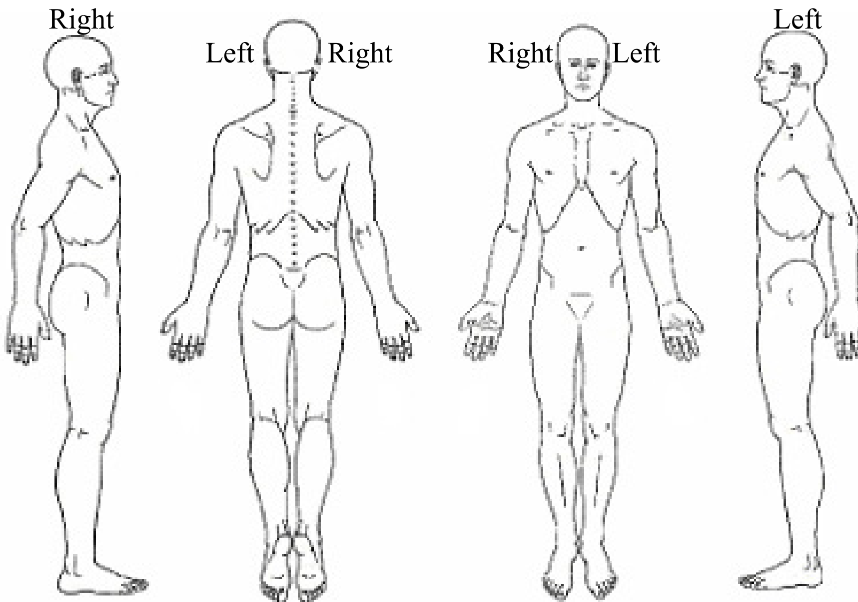
   b. ____

   c. ____

   d. ____

On the diagram below, please show where you are experiencing all of your present complaints using the following letters:

A: ache **B**: burning pain **C**: cramping **D**: dull pain **R**: throbbing pain **N**: numbness **T**: tingling



2. Do you have pain and/or difficulty performing any of the following activities? Circle all that apply.

Personal Care	Lifting	Working
Driving	Sleeping	Walking
Sitting	Standing	Recreation
Social Life	Working Out	Bending

Please Complete Next Page…

3. When do you most notice the symptoms? AM or PM

4. What makes it feel better? ______________________________

5. What makes it feel worse? ______________________________

6. Have you had imaging of the areas you are here today to evaluate? X-rays MRI CT scan Ultrasound
Please list and include area of body imaged, approximate date and imaging center where they were taken:

a. ______________________________

b. ______________________________

c. ______________________________

7. For your conditions, have you tried any of the following? When? How long? Dates used?
From – To

NSAIDS i.e. Ibuprofen, Motrin, etc. ______________________________

Muscle Relaxants ______________________________

Opioids “pain killer” ______________________________

Other Medications ______________________________

Chiropractic Care ______________________________

Physical Therapy ______________________________

Home Exercise Program ______________________________

Acupuncture ______________________________

Ice/Heat/Topical Treatments ______________________________

Massage Therapy ______________________________

8. Family History: Please circle any of the following diseases that tend to run in your family and list what relative (father, grandmother, etc.):

Diabetes ______________ Heart Disease ______________

Stroke ______________ Rheumatologic Disorder ______________

Seizure ______________ Neurologic Disorder ______________

9. Social history:

Are you pregnant or trying to get pregnant? ______________________________

Do you use tobacco products? How much? ______________

Do you use alcohol? How much? ______________

Occupation ______________________________ full time part time retired

Employer ______________________________

Please Circle Married Separated Divorced Widow Single Other

Children (ages) ______________________________

Please Complete Next Page…

10. Surgical History: Include Dates:

____

____

____

____

____

11. Past Medical History: Please circle Yes or No

High blood pressure (hypertension)	Yes	No
Heart disease, heart attack (myocardial infarction)	Yes	No
Chest pains (angina)	Yes	No
Pacemaker	Yes	No
High Cholesterol	Yes	No
Asthma	Yes	No
Allergies	Yes	No
Chronic Bronchitis	Yes	No
Blood disorders	Yes	No
Emphysema	Yes	No
Anemia	Yes	No
Diabetes	Yes	No
Lightheadedness	Yes	No
Dizziness	Yes	No
Concussion	Yes	No
Fainting	Yes	No
Anxiety/Panic Attack	Yes	No
Arthritis/Joint Pain	Yes	No

Which Joint(s)? ______________________________

Artificial Joints	Yes	No

Which Joint(s)? ______________________________

Kidney Disease/ Stones	Yes	No
Hepatitis B	Yes	No
Hepatitis C	Yes	No
Spinal cord injury	Yes	No
Traumatic brain injury	Yes	No
Ulcers	Yes	No
Vertigo	Yes	No
Gout	Yes	No
Rheumatoid arthritis	Yes	No
Rheumatologic condition	Yes	No

Other Conditions:

____

____

____