



### PATIENT INTAKE FORM

Do you or anyone in your household have Health Insurance  Yes  No

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birth Date \_\_\_\_\_

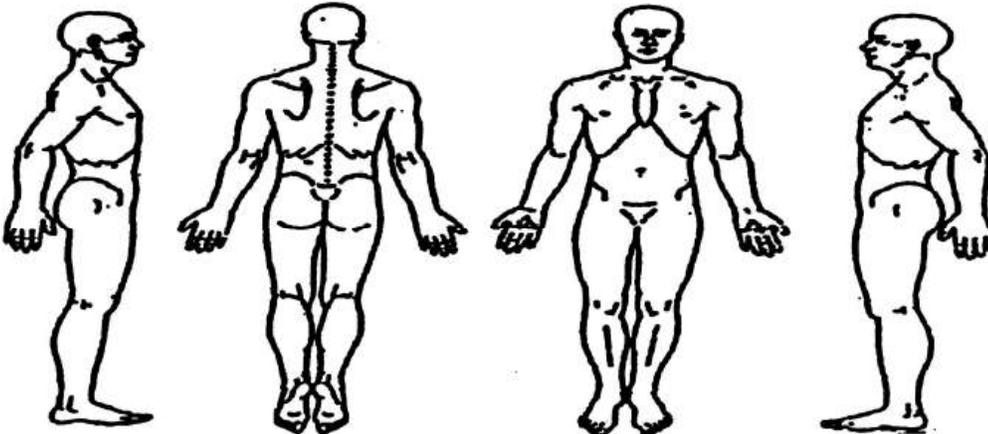
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

SS# \_\_\_\_\_ Email Address \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident  Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. 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)

First Complaint:

4. How would you describe the type of pain?  Neck Pain  Upper Back Pain  Mid-Back Pain  
 Low Back Pain  Shoulder Pain  Other: \_\_\_\_\_

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

**5. How are your symptoms changing with time?**

Getting Worse                       Staying the Same                       Getting Better

**6. 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)

**Second Complaint:**

**4A. How would you describe the type of pain?**  Neck Pain  Upper Back Pain  Mid-Back Pain

Low Back Pain  Shoulder Pain  Other: \_\_\_\_\_

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion         |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion      |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____              |

**5A. How are your symptoms changing with time?**

Getting Worse                       Staying the Same                       Getting Better

**6A. 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)

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**Third Complaint:**

**4B. How would you describe the type of pain?**  Neck Pain  Upper Back Pain  Mid Back Pain

Low Back Pain  Shoulder Pain  Other: \_\_\_\_\_

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion         |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion      |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____              |

**5B. How are your symptoms changing with time?**

Getting Worse                       Staying the Same                       Getting Better

**6B. 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)

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**7. How much has the problem interfered with your work?**

Not at all     A little bit     Moderately     Quite a bit     Extremely

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

Not at all     A little bit     Moderately     Quite a bit     Extremely

**9. Who else have you seen for your problem?**

|  |   |   |
|--|---|---|
| <input type="checkbox"/> Chiropractor      | <input type="checkbox"/> Neurologist        | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician      | <input type="checkbox"/> Orthopedist        | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No one                 |

**10. How long have you had this problem?** \_\_\_\_\_

**11. How do you think your problem began?**

Since the Accident:  Other \_\_\_\_\_

**12. Do you consider this problem to be severe?**

Yes  Yes, at times  No

**13. What aggravates your problem?**

\_\_\_\_\_ :  Always there.

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

Getting worse  Not going away  Other: \_\_\_\_\_

Prevents me from doing normal daily activities.

**15. What is your: Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Age** \_\_\_\_\_  
**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

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

Rheumatoid Arthritis  Diabetes  Lupus  
 Heart Problems  Cancer  ALS

**19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

| Past                     | Present                                       | Past                     | Present  | Past                     | Present  |
|--------------------------|---|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches            | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst        |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain      | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains                 | <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination      |
| <input type="checkbox"/> | <input type="checkbox"/> Mid Back Pain        | <input type="checkbox"/> | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> | <input type="checkbox"/> Smoking/Tobacco Use     |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain        | <input type="checkbox"/> | <input type="checkbox"/> Angina                      | <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain        | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones               | <input type="checkbox"/> | <input type="checkbox"/> Allergies               |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorders            | <input type="checkbox"/> | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain           | <input type="checkbox"/> | <input type="checkbox"/> Bladder Infection           | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus          |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain            | <input type="checkbox"/> | <input type="checkbox"/> Painful Urination           | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> | <input type="checkbox"/> Hip Pain             | <input type="checkbox"/> | <input type="checkbox"/> Loss of Bladder Control     | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash  |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Leg Pain       | <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems           | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> | <input type="checkbox"/> Knee Pain            | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Weight Gain/Loss   |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain      | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite            |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain              | <input type="checkbox"/> | <b>For Females Only</b>                          |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Ulcer                       | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills     |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement    |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy               |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer               | <input type="checkbox"/> | <input type="checkbox"/> General Fatigue             |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Tumor                | <input type="checkbox"/> | <input type="checkbox"/> Muscular In-coordination    |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma               | <input type="checkbox"/> | <input type="checkbox"/> Visual Disturbances         |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis    | <input type="checkbox"/> | <input type="checkbox"/> Dizziness                   |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____         |                          |  |                          |  |

20. List all prescription medications you are currently taking:

\_\_\_\_\_

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

\_\_\_\_\_

22. List all surgical procedures you have had:

\_\_\_\_\_

23. 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 of the day | <input type="checkbox"/> A little of the day |

24. What activities do you do outside of work?

\_\_\_\_\_

25. Have you ever been hospitalized?  No  Yes

If yes, why \_\_\_\_\_

26. Have you had significant past trauma?  No  Yes

27. Anything else pertinent to your visit today? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

# Arnel Family Chiropractic

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that it will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** *An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.*

**Health:** *A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.*

**Vertebral Subluxation:** *A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.*

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, **we do not offer to treat it.** Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*\*\*\*\* Consent to evaluate and adjust a minor child \*\*\*\*\*

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_

\_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*\*\*\*\* Pregnancy Release \*\*\*\*\*

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date