Patient History Intake Form

Patient Name: _____ Date: _____

1. Please describe the problem that brings you here, along with how and when it happened.

_____

_____

_____

_____

2. Please check whether this problem is

O Chronic (meaning persisting for a long time or constantly recurring) or

O Acute (meaning a rapid onset and occurred recently.)

3. Date of Injury:_____ Please be specific as possible.

4. Date of Surgery, if any:_____ Type of Surgery: _____

5. What makes the problem feel worse?

_____

6. What makes the problem feel better?

_____

7. What treatment have you had for this problem?
(X-Ray, MRI, Injections, Medications, acupuncture, chiropractic, etc.)

_____

_____

8. Date and location of last imaging test?

_____

9. Current medications and supplements:

_____

_____

10. Does the discomfort disturb your work? Circle one: Yes/No

_____

_____

11. Does the discomfort disturb your sleep? Circle one: Yes/No

_____

_____

12. On a scale of 1-10 with 10 being the worst pain, please rate the pain level you have today

(Circle) 1 2 3 4 5 6 7 8 9 10

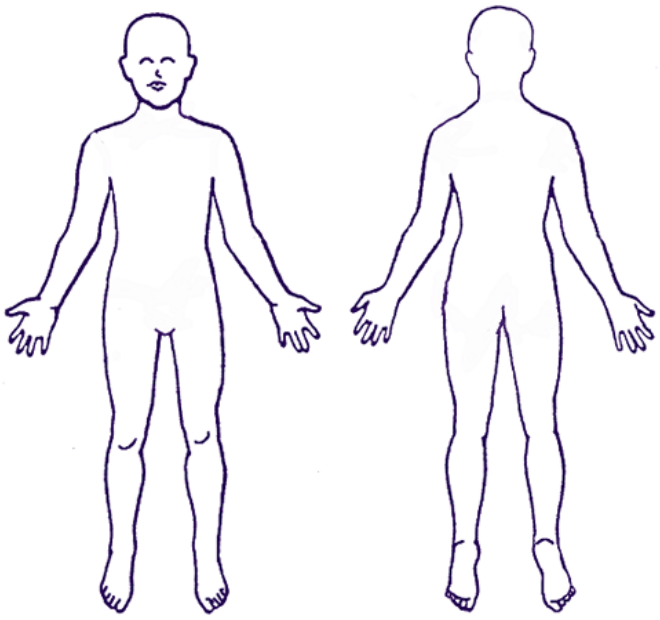
13. How would you describe the symptoms that you are experiencing? Circle all that apply

Numbness Burning

Pins & Needles Stabbing

Aching Other:_____

14. On the drawing below, please indicate the painful areas on your body that we will be treating by circling them.



15. Please list any significant medical history, surgeries, etc:

_____
_____
_____
_____
_____
_____
_____

16. Are you currently or could you be pregnant? Yes/No
17. Please describe your occupation and activities at home:

_____
_____
_____18. What are your goals for therapy:

_____
_____