Dare2Care Mobile Chiropractic Patient Intake Form

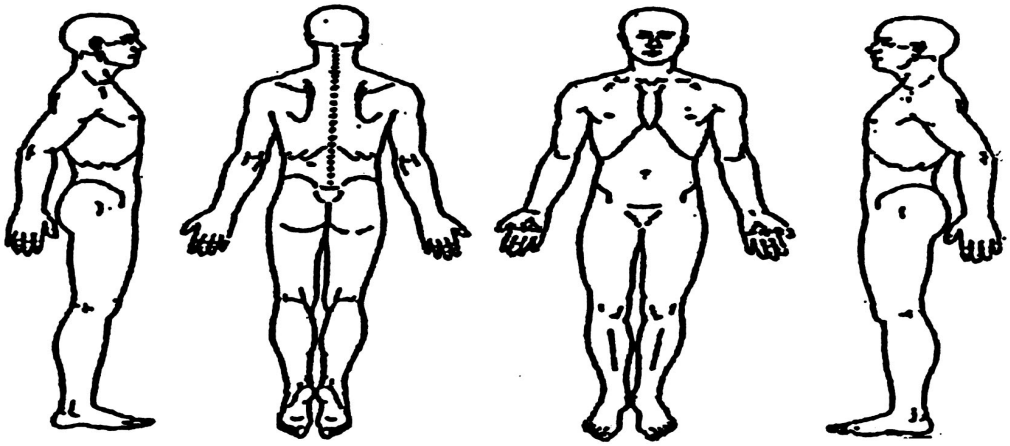
Patient Name: _____ **Date:** _____

What is your: Height_____ **Weight** _____ **Date of Birth** _____

Phone Number (_____) _____**Occupation**_____

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)

4. How would you describe the type of pain?

☐Sharp ☐Numb
☐Dull ☐Tingly
☐Diffuse ☐Sharp with motion
☐Achy ☐Shooting with motion
☐Burning ☐Stabbing with motion
☐Shooting ☐Electric like with motion
☐Stiff ☐Tearing (if in back)
☐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*)

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?

☐Chiropractor ☐Neurologist ☐Primary Care Physician
☐ER physician ☐Orthopedist ☐Other:_____
☐Massage Therapist ☐Physical Therapist ☐No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

☐Yes ☐Yes, at times ☐No

13. What aggravates your problem?

_____

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

_____

15. How would you rate your overall Health?

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

16. What type of exercise do you do?

☐Stenuous ☐Moderate ☐Light ☐None

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

☐Rheumatoid Arthritis ☐Diabetes ☐Lupus
☐Heart Problems ☐Cancer ☐ALS

18. 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
☐	☐Headaches	☐	☐High Blood Pressure	☐	☐Diabetes
☐	☐Neck Pain	☐	☐Heart Attack	☐	☐Excessive Thirst
☐	☐Upper Back Pain	☐	☐Chest Pains	☐	☐Frequent Urination
☐	☐Mid Back Pain	☐	☐Stroke	☐	☐Smoking/Tobacco Use
☐	☐Low Back Pain	☐	☐Angina	☐	☐Drug/Alcohol Dependance
☐	☐Shoulder Pain	☐	☐Kidney Stones	☐	☐Allergies
☐	☐Elbow/Upper Arm Pain	☐	☐Kidney Disorders	☐	☐Depression
☐	☐Wrist Pain	☐	☐Bladder Infection	☐	☐Systemic Lupus
☐	☐Hand Pain	☐	☐Painful Urination	☐	☐Epilepsy
☐	☐Hip Pain	☐	☐Loss of Bladder Control	☐	☐Dermatitis/Eczema/Rash
☐	☐Upper Leg Pain	☐	☐Prostate Problems	☐	☐HIV/AIDS
☐	☐Knee Pain	☐	☐Abnormal Weight Gain/Loss		
☐	☐Ankle/Foot Pain	☐	☐Loss of Appetite	**For Females Only**	
☐	☐Jaw Pain	☐	☐Abdominal Pain	☐	☐Birth Control Pills
☐	☐Joint Pain/Stiffness	☐	☐Ulcer	☐	☐Hormonal Replacement
☐	☐Arthritis	☐	☐Hepatitis	☐	☐Pregnancy
☐	☐Rheumatoid Arthritis	☐	☐Liver/Gall Bladder Disorder		
☐	☐Cancer	☐	☐General Fatigue		
☐	☐Tumor	☐	☐Muscular Incoordination		
☐	☐Asthma	☐	☐Visual Disturbances		
☐	☐Chronic Sinusitis	☐	☐Dizziness		
☐	☐Other:_____				

19. List all prescription medications you are currently taking:

_____

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

_____

21. List all surgical procedures you have had:

_____

22. What activities do you do at work?

☐**Sit:** ☐**Stand:** ☐**Computer work:** ☐**On the phone:** ☐**Driving:**

23. What activities do you do outside of work?

_____

24. Have you ever been hospitalized? ☐No ☐Yes

if yes, why _____

25. Have you had significant past trauma? ☐No ☐Yes

26. Anything else pertinent to your visit today?_____

27. Do you currently have a headache? ☐No ☐Yes

28. If Yes to 27, Please rate on a scale of 1/10? _____ Is this the worst headache you have ever experience? ☐No ☐Yes

Patient Signature_____ **Date:**_____