PATIENT INTAKE FORM

Indicate below the area(s) of pain and its intensity using the key below.

0= No pain 1= no to minimal pain 2= minimal 3= mild
4= mild to moderate 5= moderate 6= moderate to severe
7= severe 8= severe affecting activities 9= Unbearable
10= Excruciating

AREA: **INTENSITY: 0-10:**

1_____ _____

2_____ _____

3_____ _____

4_____ _____

HOW WOULD YOU DESCRIBE YOUR PAIN?

Type:

____ Sharp ____Dull ____Achy ____Stiff ____Burning
____Shooting ____Stabbing ____Numb ____Tingly

Frequency of Pain:

___Constantly (76-100% of the time) ___Frequently (51-75% of the time)

___Occasionally (26-50% of the time) ___Intermittently (1-25% of the time)

How long have you had this pain? _____

How did the problem begin? _____

Has this problem interfered with work? Y or N

Has this problem interfered with activities? Y or N

What aggravates your problem?

___Coughing ___Sneezing ___Straining ___Exercise ___Neck Movement ___Lifting
___Bending ___Twisting ___Sleeping ___Sitting ___Standing ___Walking

___Other _____

For office use only.

_____Height _____Weight _____Age _____BP

HEALTH HISTORY:

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

_____Rheumatoid Arthritis _____Diabetes _____Lupus _____Heart Problems _____Cancer

For each of the following conditions please check the appropriate box indicating "past" if you have had the condition in the past. Please Indicate "present" if you currently have a condition listed.

Condition	Past	Present
Headaches		
Neck Pain		
Mid back Pain		
Low Back Pain		
Arm Pain		
Wrist/ Hand Pain		
Hip Pain		
Knee Pain		
Ankle Pain		
Joint Pain/ Stiffness		
Arthritis		
Rheumatoid Arthritis		
Cancer		
Asthma		
High Blood Pressure		
Heart Attack		
Chest Pains		
Stroke		
Kidney Stones		
Bladder Infections		
Painful Urination		
Prostate Problems		
Hepatitis		
Liver Disorder		
Dizziness		
Diabetes		
Frequent Urination		
Tobacco Use		
Recreation Drug Use		
Alcohol Dependence		
Depression		
Lupus		
AIDS		
Rash		

HEALTH HISTORY CONTINUED

List all prescription medications you are currently taking: _____

_____

List all over the counter medication/ supplements you are currently taking: _____

_____

Have you ever been hospitalized in the past 5-6 years? Y or N

If yes, why and the date of each: _____

List all surgical procedures in the past 5-6 years: _____

Are you currently pregnant? Y or N

Do you currently have a pacemaker? Y or N

Anything else pertinent to your visit today?

_____
_____
_____
_____
_____

Patient Signature _____ **Date:** _____