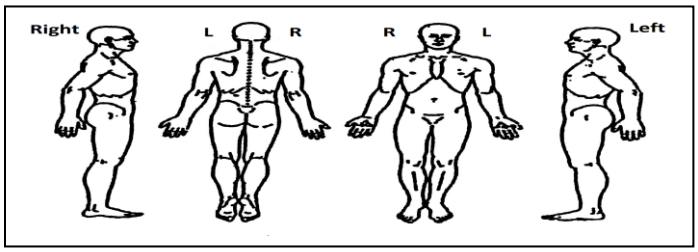
# PATIENT INTAKE FORM

Name: _____ Date: _____

**Is this?** □ Work Related □ Auto Related □ N/A




**Chief Complaint**

Where is the location of your major complaint? _____

Does the discomfort radiate (travel)? □ No □ Yes, From _____ to _____

How would you rate your level of discomfort? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Describe the discomfort? □ Dull □ Tingly □ Throbbing □ Deep □ Sharp □ Stabbing □ Achy
□ Stiff □ Numb □ Burning □ Shooting □ Other_____

How often are symptoms present? (Occasional) □ 0-25% □ 26-50% □ 51-75% □ 76-100% (Constant)

Was the onset: Gradual or Sudden

Date the problem begin? _____

What caused the problem to begin? _____

Are your symptoms? □ Getting Worse □ Staying the Same □ Getting Better

What aggravates your discomfort? _____

What relieves your discomfort? _____

**Additional Complaint**

Where is the location of your additional complaint? _____

Does the discomfort radiate (travel)? □ No □ Yes, From _____ to _____

How would you rate your level of discomfort? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Describe the discomfort? □ Dull □ Tingly □ Throbbing □ Deep □ Sharp □ Stabbing □ Achy
□ Stiff □ Numb □ Burning □ Shooting □ Other_____

How often are symptoms present? (Occasional) □ 0-25% □ 26-50% □ 51-75% □ 76-100% (Constant)

Was the onset: Gradual or Sudden

Date the problem begin? _____

What caused the problem to begin? _____

Are your symptoms? □ Getting Worse □ Staying the Same □ Getting Better

What aggravates your discomfort? _____

What relieves your discomfort? _____

In the past week, how much has the pain interfered with your daily activities (e.g., work, social activities, household)?
(No interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to carry on any activities)

Would you say that your overall health right now is: □ Excellent □ Very Good □ Good □ Fair □ Poor

Have you had spinal x-rays, MRI, CT Scan for your area(s) of complaint? □ Yes □ No

Date(s) taken_____ What areas were taken?_____

**Patient Signature** _____ **Date** _____