**Aarya Chiropractic**

 **PATIENT INTAKE FORM**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Name\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Identification #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of primary policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth of Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**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 □ 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. What is your: Height**\_\_\_\_\_\_\_\_\_\_\_ **Weight** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_

**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**

□ □ 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 Dependence

□ □ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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?**

□ **Sit:** □ Most of the day □ Half the day □ A little of the day

□ **Stand:** □ Most of the day □ Half the day □ A little of the day

□ **Computer work:** □ Most of the day □ Half the day □ A little of the day

□ **On the phone:** □ Most of the day □ Half of the day □ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**