Patient Intake

1. First Name: Last Name: DOB:

2. MRN #:

PATIENT INTAKE

Welcome to our online intake form. The information you fill in will be sent directly to our office, speeding up your office visit and allowing us to better serve your healthcare needs.

ABOUT YOU

3. Home Address

Address 1 Address 2

City State Zip Code

4. Contact Information

Mobile Phone Home Phone

Primary Email Address

5. Demographic Information

Sex at birth:
◯ Male ◯ Female

Marital Status:
◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Other

6. Spouse's Name:

7. Number of Children:

8. Personal Information

Height - Feet: Height - Inches:

Weight (in pounds):

9. Do you have insurance?

○ Yes ○ No

10. Insurance Payer

Insurance Payer

11. Insurance Policy Information:

Insurance Plan Name | ID/Policy Number: | Group Number:

Relationship to Patient:

○ Self ○ Spouse ○ Parent ○ Employer ○ Caregiver ○ Other

Insured's First & Last Name: | Insured's Date of Birth:

12. Insurance Card Upload

13. Emergency Contact Information

Emergency Contact Name: | Contact Phone Number: | Relationship to Patient:

14. Employer Information

Employment Status:

○ Employed ○ Student ○ Not Employed ○ Retired ○ Unknown

Employer Name: | Occupation:

Physical Work Duties:

15. Referral Information

Referring Physician: | Referring Patient:

How did you hear about us?

○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Other:

VISIT PURPOSE

16. **Select the main reason for this visit:**

- ○ Auto Accident (job related)
- ○ Auto Accident (personal)
- ○ Work Injury (not auto related)
- ○ Other (not related to an auto accident or work injury)

AUTO ACCIDENT

17. When did the accident occur?

Where in the vehicle were you at the time of the accident?

In what direction were you looking at the time of impact?

18.

	Yes	No/Unsure
Were you wearing a seatbelt?	☐	☐
Did the airbag deploy?	☐	☐
Did you come in contact with anything at the time of the collision?	☐	☐
Did you receive an injury to the head?	☐	☐
Did you lose consciousness?	☐	☐
Did your head hit the headrest?	☐	☐

19. **Which part of your vehicle was impacted? Choose all that apply.**

	Yes	No
Front right	☐	☐
Front left	☐	☐
Front head on	☐	☐
Rear end- center	☐	☐
Rear right	☐	☐
Rear left	☐	☐
Right side (passenger's side)	☐	☐
Left side (driver's side)	☐	☐
Unknown	☐	☐

20. In what direction was your vehicle moving?

○

What was the approximate speed of your vehicle?

What was the extent of the damage to your vehicle?

In what direction was the other vehicle moving?

What was the approximate speed of the other vehicle?

What was the extent of the damage to the other vehicle?

21.

	Yes	No
Was your vehicle towed from the scene?	☐	☐
Did police arrive at the scene?	☐	☐
Was an accident report taken?	☐	☐
Did Emergency Medical Services arrive at the scene?	☐	☐

22. How did you leave the scene of the accident?

23. Where was discomfort felt immediately following the accident? Choose all that apply.

	Yes	No
Abdomen	☐	☐
Back	☐	☐
Chest	☐	☐
Face	☐	☐
Head	☐	☐
Neck	☐	☐
Right shoulder, elbow, arm or hand	☐	☐
Left shoulder, elbow, arm or hand	☐	☐
Right hip, thigh, knee, leg or foot	☐	☐
Left hip, thigh, knee, leg or foot	☐	☐

24. Are you working with an attorney?

○ Yes ○ No

WORK INJURY

25. What type of accident caused your injury?

☐ Bending ☐ Carrying ☐ Climbing ☐ Crawling ☐ Jumping ☐ Kneeling ☐ Lying down ☐ Lifting ☐ Pulling ☐ Pushing ☐ Raising arm(s) above shoulder(s) ☐ Running ☐ Performing repetitive motions ☐ Sitting ☐ Squatting ☐ Prolonged Standing ☐ Talking on the phone ☐ Traveling ☐ Turning ☐ Twisting ☐ Typing ☐ Using a computer ☐ Walking ☐ Other job related activity ☐ Other non-job related activity

When did the accident occur?

_____

26.

	Yes	No
Did you receive an injury to the head?	☐	☐
Did you lose consciousness?	☐	☐
Did police arrive at the scene?	☐	☐
Was an accident report taken?	☐	☐
Did Emergency Medical Services arrive at the scene?	☐	☐

27. How did you leave the scene of the accident?

_____

28. Where was discomfort felt immediately following the accident? Choose all that apply.

	Yes	No
Abdomen	☐	☐
Back	☐	☐
Chest	☐	☐
Face	☐	☐
Head	☐	☐
Neck	☐	☐
Right shoulder, elbow, arm or hand	☐	☐
Left shoulder, elbow, arm or hand	☐	☐
Right hip, thigh, knee, leg or foot	☐	☐
Left hip, thigh, knee, leg or foot	☐	☐

AREAS OF CONCERN

29. What is your primary area of concern? We will ask about additional complaints after we gather information about this first area of concern.

_____

_____

_____

_____

30. What term(s) describes your discomfort after the accident? Choose all that apply.

	Yes	No
Aching	☐	☐
Burning	☐	☐
Deep	☐	☐
Dull	☐	☐
Intolerable	☐	☐
Sharp	☐	☐
Shooting	☐	☐
Stabbing/Throbbing	☐	☐
Stiffness	☐	☐
Tightness	☐	☐
Tingling	☐	☐
Other	☐	☐

If other, specify:

_____

31. What treatment, if any, have you received since the accident? Choose all that apply.

	Yes	No
Hospitalization	☐	☐
Surgery	☐	☐
Acupuncture	☐	☐
Chiropractic care	☐	☐
Injection therapy	☐	☐
Massage	☐	☐
Naturopathic medicine	☐	☐
Physical therapy	☐	☐
Primary care physician visit	☐	☐
Over-the-counter medications	☐	☐
Prescribed medications	☐	☐
Heat or cold therapy	☐	☐
None	☐	☐
Other	☐	☐

If other, specify:

_____

32. Are there any additional symptoms which have appeared since the accident occurred? Choose all that apply.

	Yes	No
Breathing difficulty	☐	☐
Muscle spasm	☐	☐
Chest pain	☐	☐
Numbness and tingling	☐	☐
Depression	☐	☐
Rib pain	☐	☐
Facial pain	☐	☐
Stomach pain	☐	☐
Genital pain	☐	☐
Headaches	☐	☐
Tightness	☐	☐
Soreness	☐	☐
Shock	☐	☐
Dizziness	☐	☐
Sleeping difficulty	☐	☐
Stress	☐	☐
Gluteal pain	☐	☐
Irritability	☐	☐
Stunned	☐	☐
Tiredness	☐	☐
Loss of appetite	☐	☐
Anxiety	☐	☐
Low energy	☐	☐
None	☐	☐
Other	☐	☐

If other, specify:

_____

33. Have your symptoms changed since the accident? Choose all that apply.

	Yes	No
Improved daily functioning at home/work	☐	☐
Shown no change in daily functioning at home/work	☐	☐
Deteriorated daily functioning at home/work	☐	☐
Symptoms have exacerbated	☐	☐
Symptoms have disappeared	☐	☐
Elicited more pain	☐	☐
Elicited more stiffness	☐	☐

34. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

How often do you feel this discomfort?

35. Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

36. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement	☐	☐
Athletic activity and/or exercise	☐	☐
Bending	☐	☐
Carrying or lifting	☐	☐
Changing positions	☐	☐
Coughing and/or sneezing	☐	☐
Daily child or pet care	☐	☐
Getting out of bed, chair or car	☐	☐
Household chores (cleaning, cooking, etc.)	☐	☐
Looking over shoulder	☐	☐
Lying down, getting and staying asleep	☐	☐
Pulling, pushing or reaching	☐	☐
Raising arm(s) above shoulder(s)	☐	☐
Self care (dressing, bathing, etc.)	☐	☐
Sitting in car or chair	☐	☐
Squatting or bending	☐	☐
Standing	☐	☐
Stress	☐	☐
Walking or running	☐	☐
Working at a desk/computer	☐	☐
Yardwork	☐	☐
Unknown	☐	☐
Other	☐	☐

If other, specify:

_____

37. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Nothing	☐	☐
Chiropractic adjustment	☐	☐
Prescription medications	☐	☐
Cold packs	☐	☐
Redirecting attention	☐	☐
Exercise	☐	☐
Rest	☐	☐
Heat packs	☐	☐
Stretching	☐	☐
Massage	☐	☐
Work	☐	☐
Over-the-counter medications	☐	☐
Physical therapy	☐	☐
Other	☐	☐

If other, specify:

_____

38. Have other health care provider(s) performed tests related to this condition?

○ Yes ○ No

If Yes, specify:

_____

39. Have you ever had any previous episodes of this condition?

○ Yes ◉ No

If Yes, specify:

_____

40. Do you have an additional condition?

○ Yes ◉ No

If Yes, specify:

_____

AREAS OF CONCERN

41. Approximate date this condition began (exact date not required)

What caused this condition?

What is your primary area of concern? We will ask about additional complaints after we gather information about this first area of concern. Describe primary body area of concern:

42. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching	☐	☐
Burning	☐	☐
Deep	☐	☐
Dull	☐	☐
Intolerable	☐	☐
Sharp	☐	☐
Shooting	☐	☐
Stabbing/Throbbing	☐	☐
Stiffness	☐	☐
Tightness	☐	☐
Tingling	☐	☐
Other	☐	☐

If other, specify:

43. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

How often do you feel this discomfort?

How has this complaint changed since onset?

Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

44. What treatment, if any, have you received since the injury? Choose all that apply.

	Yes	No
Chiropractic care	☐	☐
Massage	☐	☐
Medical injection treatment	☐	☐
Surgical treatment	☐	☐
Over-the-counter medications	☐	☐
Prescribed medications	☐	☐
Natural or holistic treatment	☐	☐
Acupuncture	☐	☐
Physical therapy	☐	☐
None	☐	☐
Other	☐	☐

If other, specify:

_____

45. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement	☐	☐
Athletic activity and/or exercise	☐	☐
Bending	☐	☐
Carrying or lifting	☐	☐
Changing positions	☐	☐
Coughing and/or sneezing	☐	☐
Daily child or pet care	☐	☐
Getting out of bed, chair or car	☐	☐
Household chores (cleaning, cooking, etc.)	☐	☐
Looking over shoulder	☐	☐
Lying down, getting and staying asleep	☐	☐
Pulling, pushing or reaching	☐	☐
Raising arm(s) above shoulder(s)	☐	☐
Self care (dressing, bathing, etc.)	☐	☐
Sitting in car or chair	☐	☐
Squatting or bending	☐	☐
Standing	☐	☐
Stress	☐	☐
Walking or running	☐	☐
Working at a desk/computer	☐	☐
Yardwork	☐	☐
Unknown	☐	☐
Other	☐	☐

If other,specify:

_____

46. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Chiropractic adjustment	☐	☐
Prescription medications	☐	☐
Cold packs	☐	☐
Redirecting attention	☐	☐
Exercise	☐	☐
Rest	☐	☐
Heat packs	☐	☐
Stretching	☐	☐
Massage	☐	☐
Work	☐	☐
Over-the-counter medications	☐	☐
Physical therapy	☐	☐
Nothing	☐	☐
Other	☐	☐

If other, specify:

_____

47. Have other health care provider(s) performed tests related to this condition?

◯ Yes ◯ No

If Yes, specify:

_____

48. Have you ever had any previous episodes of this condition?

◯ Yes ◯ No

If Yes, specify:

_____

49. Do you have an additional condition?

◯ Yes ◯ No

ADDITIONAL AREA OF CONCERN

50. Approximate date this condition began (exact date not required)

_____

What caused this condition?

What is your additional area of concern?

51. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching	☐	☐
Burning	☐	☐
Deep	☐	☐
Dull	☐	☐
Intolerable	☐	☐
Sharp	☐	☐
Shooting	☐	☐
Stabbing/Throbbing	☐	☐
Stiffness	☐	☐
Tightness	☐	☐
Tingling	☐	☐
Other	☐	☐

If other, specify:

52. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

How often do you feel this discomfort?

How has this complaint changed since onset?

Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

53. What treatment, if any, have you received since the injury? Choose all that apply.

	Yes	No
None	☐	☐
Chiropractic care	☐	☐
Massage	☐	☐
Medical injection treatment	☐	☐
Surgical treatment	☐	☐
Over-the-counter medications	☐	☐
Prescribed medications	☐	☐
Natural or holistic treatment	☐	☐
Acupuncture	☐	☐
Physical therapy	☐	☐
Other	☐	☐

If other, specify:

_____

54. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement	☐	☐
Athletic activity and/or exercise	☐	☐
Bending	☐	☐
Carrying or lifting	☐	☐
Changing positions	☐	☐
Coughing and/or sneezing	☐	☐
Daily child or pet care	☐	☐
Getting out of bed, chair or car	☐	☐
Household chores (cleaning, cooking, etc.)	☐	☐
Looking over shoulder	☐	☐
Lying down, getting and staying asleep	☐	☐
Pulling, pushing or reaching	☐	☐
Raising arm(s) above shoulder(s)	☐	☐
Self care (dressing, bathing, etc.)	☐	☐
Sitting in car or chair	☐	☐
Squatting or bending	☐	☐
Standing	☐	☐
Stress	☐	☐
Walking or running	☐	☐
Working at a desk/computer	☐	☐
Yardwork	☐	☐
Unknown	☐	☐
Other	☐	☐

If other,specify:

_____

55. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Nothing	☐	☐
Chiropractic adjustment	☐	☐
Prescription medications	☐	☐
Cold packs	☐	☐
Redirecting attention	☐	☐
Exercise	☐	☐
Rest	☐	☐
Heat packs	☐	☐
Stretching	☐	☐
Massage	☐	☐
Work	☐	☐
Over-the-counter medications	☐	☐
Physical therapy	☐	☐
Other	☐	☐

If other, specify:

_____

56. Have other health care provider(s) performed tests related to this condition?

◯ Yes ◯ No

57. Have you ever had any previous episodes of this condition?

◯ Yes ◯ No

CURRENT HEALTH

58. Are you currently taking any medications?

◯ Yes ◯ No

59. Please list regularly used prescription and over-the-counter medications taken, as well as the Dosage and Frequency for each medication (e.g. 5 mg once daily)

	Medication Name	Dosage/Frequency
1		
2		
3		

60. Other than the condition(s) already shared, do you have any additional health concerns?

	Yes	No
Muscles, Bones or Joints	☐	☐
Nerves, Headaches, Dizziness, or Emotional	☐	☐
Head, Eyes, Ears, Nose or Throat	☐	☐
Heart, Blood Pressure, or Circulation	☐	☐
Shortness of Breath, Coughing, Asthma or Lung Condition	☐	☐
Stomach, Bowels or Digestive Conditions	☐	☐
Genital, Bladder, or Urinary Conditions	☐	☐
Diabetes, Thyroid or Glandular Condition	☐	☐
Skin or Bleeding Conditions	☐	☐
Do you have any medication allergies?	☐	☐

61. If you have answered yes to any of the above, please share this info with your doctor.

62. Medication Allergies

	Medication Name	Reaction	Onset Date	Additional Comments
1				
2				
3				

PERSONAL AND FAMILY HISTORY

63.

	Yes	No
Have you had any surgical procedures?	☐	☐
Are there any past illnesses or conditions we should be aware of?	☐	☐
Do you have a past history of accidents or trauma?	☐	☐
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?	☐	☐

64. If you have answered yes to any of the above, please share this info with your doctor.

WORK, SOCIAL, HABITS

65. Current work habits - Choose all that apply.
☐ Permanently fully disabled ☐ Permanently partially disabled ☐ Cannot work due to current condition
☐ Full-time (20-40+ hours/week) ☐ Part-time (1-19 hours/week) ☐ Retired ☐ Student ☐ Homemaker
☐ Unemployed

66. Personal social habits

	Yes	No
Smoke or use tobacco products	☐	☐
Drink alcohol	☐	☐
Drink caffeine	☐	☐
Use recreational drugs	☐	☐
Other, to be discussed with doctor	☐	☐

67. Present exercise habits

	Yes	No
No current exercise	☐	☐
Exercise daily	☐	☐
Exercise 3+ times per week	☐	☐
Cannot return to exercise due to current condition	☐	☐

68. Diet and nutrition habits

	Yes	No
Vegan or vegetarian	☐	☐
Daily supplements	☐	☐
Other	☐	☐

69. _____

_____

_____

70. _____