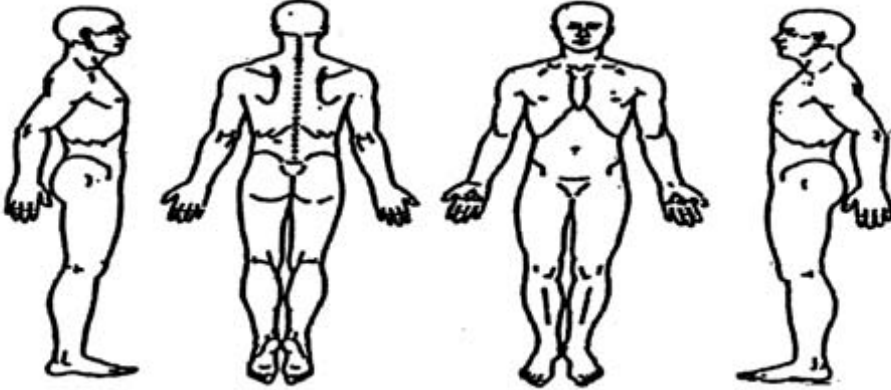


# NEW PATIENT CONFIDENTIAL INTAKE FORM Page 3

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

1. Is today's problem caused by:  Auto Accident  Workman's Compensation  Other

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?

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12. Do you consider this problem to be severe?

- Yes  Yes, at times  No

13. What aggravates your problem?

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

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15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

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

20. List all prescription medications you are currently taking:

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

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22. List all surgical procedures you have had:

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**23. What activities do you do at work?**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

**24. What activities do you do outside of work?**

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**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?** \_\_\_\_\_

Would you like our doctors to have open oral or written discussion with your other doctors to help your case?      YES      NO

If so, who is your current "general medical" health practitioner? Give name, city, phone and fax if you can:

M.D. Name: \_\_\_\_\_

The doctors and staff of Budincich Chiropractic Clinic (BCC) have my permission to request any and all medical records, x-rays, or diagnostic tests or imaging from my past physicians or surgeons, to fully appraise my condition, and to determine safe treatment protocols. I understand that I must pay any fees, if any are assessed, to prior doctors and clinics to have such records mailed to BCC. I also authorize my personal medical insurance company, or third party insurance company responsible, to pay any and all contracted amounts directly to BCC and this document may be considered a pre-designated "ASSIGNMENT OF BENEFITS" as authorized by my signature below:

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Secondary Doctor/Intern Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_