**PATIENT INTAKE FORM (Page 2)**

**11. Do you consider this problem to be severe?**

**o Yes o Yes, at times o No**

**12. What aggravates your problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**13. What concerns you the most about your problem; what does it prevent you from doing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**14. What alleviates your problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**15. What is your: Height \_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**16. What type of exercise do you do? o Strenuous o Moderate o Light o None**

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

**o Rheumatoid Arthritis o Diabetes o Lupus**

**o Heart Problems o Cancer o ALS**

**18. For each of the conditions listed below, place a check in the “past” column if you have had the condition in the past and a check in the “present” column if you presently have any of the following conditions. Please note that in each column past is on the left side.**

**Past Present Past Present Past Present**

**o o Headaches o o High Blood Pressure o o Diabetes**

**o o Neck Pain o o Heart Attack o o Excessive Thirst**

**o o Upper back pain o o Chest Pains o o Frequent Urination**

**o o Mid Back Pain o o Stroke o o Smoking/Tobacco use**

**o o Low Back Pain o o Angina o o Drug/Alcohol Dependence**

**o o Shoulder Pain o o Kidney Stones o o Allergies**

**o o Elbow/Upper Arm Pain o o Kidney Disorders o o Depression**

**o o Wrist Pain o o Bladder Infection o o Systemic Lupus**

**o o Hand Pain o o Painful Urination o o Epilepsy**

**o o Hip Pain o o Loss of Bladder Control o o Dermatitis/Eczema/Rash**

**o o Upper Leg Pain o o Prostate Problems o o HIV/AIDS**

**o o Knee Pain o o Abnormal Weight Gain/Loss o o Visual Disturbances**

**o o Ankle/Foot Pain o o Loss of Appetite o o Dizziness**

**o o Jaw Pain o o Abdominal Pain o o Asthma**

**o o Joint Pain/Stiffness o o Ulcer o o Chronic Sinusitis**

**o o Arthritis o o Hepatitis For Females Only**

**o o Rheumatoid Arthritis o o Liver/Gall Bladder Disorder o o Birth Control Pills**

**o o Cancer o o General Fatigue o o Hormonal Replacement**

**o o Tumor o o Muscular Incoordination o o Pregnancy**

**o o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**19. List all prescription medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**20. List all over the counter medications you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**21. List all surgical procedures you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

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

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

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

**o On the phone o Most of the day o Half the day o A little of the day**

**23. What activities do you do outside of work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**24. Have you ever been hospitalized? o No o Yes**

**If yes, why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**25. Have you had significant trauma? o No o Yes**

**26. Anything else pertinent to your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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