ORIGINAL

Thompson FAMILY CHIROPRACTIC

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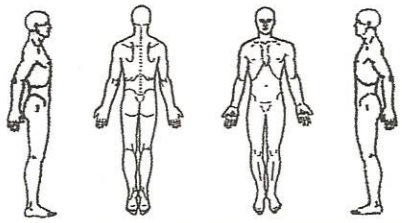
Patient Intake Form

1. Indicate with an X on the drawings below where you have pain/symptoms.



Please list/Describe your symptoms in order of Severity

1. _____
2. _____
3. _____
4. _____
5. _____

2. How often do you experience your symptoms?
   - ❑ Constantly (76-100% of the time)
   - ❑ Frequently (51-75% of the time)
   - ❑ Occasionally (26-50% of the time)
   - ❑ Intermittently (1-25% of the time)
3. How would you describe the type of pain?
   - ❑ Sharp
   - ❑ Diffuse
   - ❑ Dull
   - ❑ Electric like with motion
   - ❑ Tingly
   - ❑ Shooting
   - ❑ Achy
   - ❑ Numb
   - ❑ Stiff
   - ❑ Burning
   - ❑ Other _____
   - ❑ Sharp with motion
   - ❑ Shooting with motion
   - ❑ Stabbing with motion
4. How are your symptoms changing with time.
   - ❑ Getting Worse
   - ❑ Not Changing
   - ❑ Getting Better
5. 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)*
6. How much has the problem interfered with your work?
   - ❑ Not at all
   - ❑ A little bit
   - ❑ Moderately
   - ❑ Quite a bit
   - ❑ Extremely
7. How much has the problem interfered with your social activities?
   - ❑ Not at all
   - ❑ A little bit
   - ❑ Moderately
   - ❑ Quite a bit
   - ❑ Extremely
8. Who else have you seen for your problem?
   - ❑ Chiropractor
   - ❑ ER Physician
   - ❑ Massage Therapist
   - ❑ Neurologist
   - ❑ Orthopedist
   - ❑ Physical Therapist
   - ❑ Primary Care Physician
   - ❑ Other _____
   - ❑ No One
9. How long have you had this problem? _____
10. How do you think your problem began?

    _____
11. Do you consider this problem to be severe?
    - ❑ Yes
    - ❑ Yes, at times
    - ❑ No
12. What aggravates your problem?

    _____
13. What makes your problem better?

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

    _____