2087 GRAND CANAL BLVD, SUITE 12
STOCKTON, CA 95207
PHONE: 209-888-8602
FAX: 209-888-8603

MEDICAL HISTORY INTAKE FORM

(Mark a ✓ on each that applies)

Referred by: _____ Account No.: _____ Date: _____

Full Name: _____

Gender: ☐M ☐F Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced Age: _____

Birth Date: ___/___/____ Height _____ Weight _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security No.: _____-_____-_____ Driver's License No.: _____

Home Phone: (___) _____ Cellular Phone.: _____

Who Referred you: _____

Employer: _____ Work Phone: (____) _____

Email: _____

****

INSURANCE INFORMATION:

Insured's Name: _____
(Last) (First) (Init)

Relation to patient: _____ D.O.B.: _____ Soc. Sec. #: _____

Insurance Company: _____

ID#: _____ Group #: _____

☐ ☐ ☐ ☐

****

OTHER DOCTORS SEEN:

☐ Orthopedist ☐ Neurologist ☐ Psychiatrist ☐ Physiatrist ☐ Chiropractor
☐ Acupuncturist ☐ General Practitioner ☐ Physical Therapist ☐ Massage Therapist
☐ Other

SYMPTOMATOLOGY: (Pain characteristics for major area of complaint)

How and when did the pain start: _____

_____

The pain is made **better** by: _____

_____

and **worse** by: _____

_____

☐ ☐ ☐ ☐ ☐

There is / There isn't **radiation** into: _____

_____

There is / There isn't **parentheses (tingling/numbness)** into: _____

_____

The pain is **located:** _____

_____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.):_____

_____

DAILY ACTIVITIES:

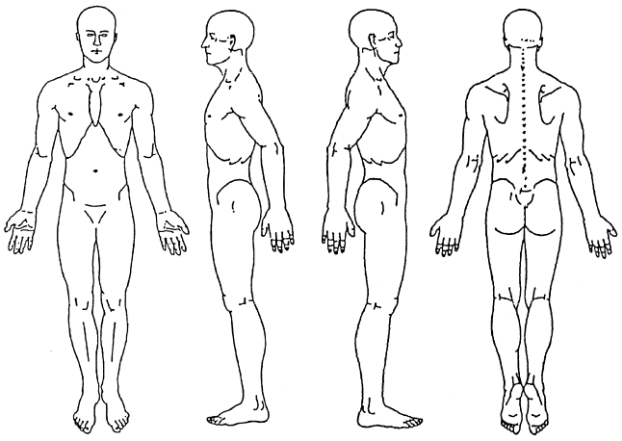
How many days out of an average week do you have pain? ☐ >1 ☐ 2-5 ☐ 5-7
How much time out of an average day are you in pain? ☐ Always ☐ Sometimes ☐ Never
What are the worst times of day for the pain? ☐ Morning ☐ Noon ☐ Evening ☐ Other
When do you feel the best? ☐ Morning ☐ Noon ☐ Evening ☐ Other

PAIN RATING:

On a scale of 0 – 10, rate your pain: (Please O the number that best describes your pain)

No Pain Severe Pain
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Please use the legend symbols below to accurately mark the areas in which you feel these sensations:
Stabbing/Cutting-//// Tingling-**** Burning-XXXX Cramping- ^^^^
Numbness-NNNN Dull-####



Describe the overall severity of the pain:
☐ Mild Nuisance ☐ Mild to moderate, but can live with it
☐ Moderate, having trouble coping with it ☐ Severe, it is ruining my quality of life

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	☐	☐	☐	_____
Walking	☐	☐	☐	_____
Standing	☐	☐	☐	_____
Lying Down	☐	☐	☐	_____
Looking up	☐	☐	☐	_____
Looking Down	☐	☐	☐	_____
Lifting	☐	☐	☐	_____

PROGRESSION:

How is your pain compared to when the pain episode first started?

☐ Much Improved ☐ Somewhat Improved ☐ Much Worse ☐ Somewhat Worse ☐ No Change

What do you do to relieve the pain?

_____

_____

Please mark a ✓ on each that applies to your daily activities:

☐ Have difficulty climbing stairs.
☐ Have to use handrails to get up stairs, etc.
☐ Have to hold onto something to sit or stand from a chair.
☐ Stay at home most of the time.
☐ Do not do jobs around the house.
☐ Walk slower than usual.
☐ Can only walk short distances.
☐ Have to sit most of the day.
☐ Can only stand for short periods of time.
☐ Stays in bed most of the day.
☐ Change position frequently to try and get comfortable.
☐ Have difficulty turning over in bed.
☐ Have to lie down and rest frequently.
☐ Have difficulty sleeping.
☐ Have to get other people to do things for me.
☐ Have difficulty getting dressed.
☐ Have to get dressed with someone's help.
☐ Have difficulty bending or kneeling.
☐ Have a loss of appetite.
☐ Have more irritable stages.

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before?

_____

_____

How often do you have to stop activities and sit or lie down to control your symptoms?
☐ Several Times ☐ Occasionally ☐ Approximately _____ per day ☐ Never ☐ All Day

List your hobbies & exercise activities _____

_____

SOCIAL HISTORY:

☐ Smoker ☐ Non-Smoker ☐ Do not drink alcohol ☐ Drink alcohol
How much? _____ How often? _____
☐ Do not take drugs ☐ Take Drugs How much? _____ How often? _____
Number of Children: _____

MEDICAL HISTORY:

List any medical professionals you have seen for this problem: _____

List any medications you are currently taking: _____

_____

List the treatments you have had for your problem:
☐ Chiropractic ☐ Osteopathy ☐ Trigger Point Injections ☐ Epidural Injections
☐ Acupuncture ☐ Hot packs ☐ Ultrasound ☐ Massage
☐ Electrical Stimulation ☐ Strengthening Exercises ☐ Aerobics
☐ Bed Rest ☐ Back Brace ☐ Other: _____

List the types of Diagnostic Testing that has been performed for this problem:
☐ X-Rays ☐ C.T. Scan ☐ M.R.I. Scan ☐ Discogram ☐ Bone Scan
☐ E.M.G.

List Past Surgeries: ☐ None

_____

_____

List Past Hospitalizations: ☐ None

_____

_____

List previous back, neck and musculoskeletal problems:

_____

_____

MEDICAL HISTORY:

Do you have or have you ever had diseases or conditions of (please check Yes or No)

Respiratory:

Bronchitis	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐
Asthma	Yes ☐ No ☐
Chronic Cough	Yes ☐ No ☐
Morning Cough	Yes ☐ No ☐
Shortness of Breath	Yes ☐ No ☐
Wheezing	Yes ☐ No ☐

Cardiovascular:

High Blood Pressure	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐
Arrhythmia	Yes ☐ No ☐
Phlebitis	Yes ☐ No ☐
Hardening of the Arteries	Yes ☐ No ☐
Artificial Valve	Yes ☐ No ☐
Pacemaker	Yes ☐ No ☐

Other Systemic:

Hepatitis	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐
Thyroid Problems	Yes ☐ No ☐
Kidney Disease	Yes ☐ No ☐
Dialysis	Yes ☐ No ☐
Bladder Problems	Yes ☐ No ☐

Gastrointestinal

Stomach absorptive disorder	Yes ☐ No ☐
Nausea, vomiting, diarrhea when taking antibiotics	Yes ☐ No ☐
Yeast infection when taking antibiotics	Yes ☐ No ☐
Arthritis/joint Deformity	Yes ☐ No ☐
Artificial Joint	Yes ☐ No ☐
Convulsions	Yes ☐ No ☐
Epilepsy, Seizures	Yes ☐ No ☐
Fainting	Yes ☐ No ☐

Do you have any current problems with:

☐ Anxiety ☐ Depression ☐ Irritability ☐ Other: _____

Do you have a home exercise program that you follow on a regular basis?

☐ Yes ☐ No

NOTES:

_____

_____

_____

_____

_____ _____

Signature Date