TAYLOR CHIROPRACTIC CLINIC
DR. VIRGIL TAYLOR

*DATE*_____

CONFIDENTIAL PATIENT INFORMATION

*LAST NAME*_____ *FIRST*_____ *MIDDLE*_____

*ADDRESS*_____ *CITY*_____ *STATE*_____ *ZIP*_____

*PHONE#*_____ *WORK#*_____ *CELL#*_____ *DOB*_____

*AGE*_____ *SEX*_____ *SOCIAL SECURITY#*_____ *EMAIL*_____

*EMPLOYER*_____ *CITY*_____ *STATE*_____

*NAME OF SPOUSE*_____ *SPOUSE DATE OF BIRTH*_____

*SPOUSE EMPLOYED BY*_____ *PHONE#*_____

*NAME OF RELATIVE*_____ *ADDRESS*_____

*CITY*_____ *STATE*_____ *ZIP*_____ *PHONE#*_____

*REFERRED TO THIS OFFICE BY:*_____

*GENERAL PHYSICIAN*_____ *CITY*_____ *PHONE#*_____

*INSURANCE:PRIMARY*_____ *SECONDARY*_____

PLEASE DO NOT WRITE BELOW THIS LINE!FOR DOCTORS USE ONLY

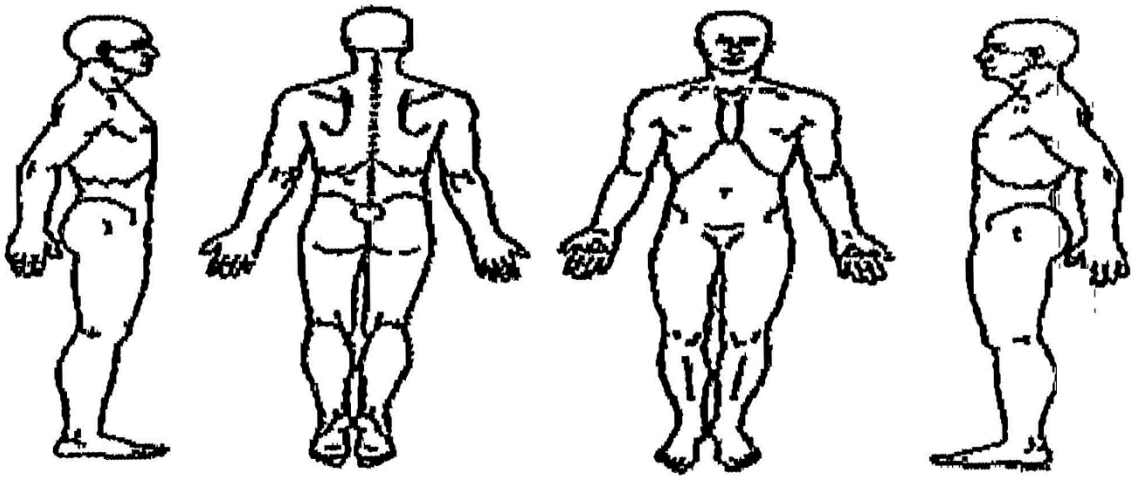
CHIEF COMPLAINT:

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

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

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)
   - ▫ Frequently (51-75% of the time)
   - ▫ Occasionally (26-50% of the time)
   - ▫ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
   - ▫ Sharp
   - ▫ Dull
   - ▫ Diffuse
   - ▫ Achy
   - ▫ Burning
   - ▫ Shooting
   - ▫ Stiff
   - ▫ Numb
   - ▫ Tingly
   - ▫ Sharp with motion
   - ▫ Shooting with motion
   - ▫ Stabbing with motion
   - ▫ Electric like with motion
   - ▫ 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
   - ▫ ER physician
   - ▫ Massage Therapist
   - ▫ Neurologist
   - ▫ Orthopedist
   - ▫ Physical Therapist
   - ▫ Primary Care Physician
   - ▫ Other:_____
   - ▫ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?
    ▫ Yes ▫ Yes, at times ▫ No

13. What aggravates your problem?

_____

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

_____

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

20. List all prescription medications you are currently taking:
_____

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

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ Sit:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half of the day	□ A little of the day

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

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?_____

Patient Signature_____ Date:_____