North Brunswick CHIROPRACTIC

NON-SURGICAL SPINAL DECOMPRESSION INTAKE FORM

www.LelandChiro.com | 509 Olde Waterford Way, STE 201 Leland, NC 28451 | (910) 371-1200

PATIENT INFORMATION

Name:_____ Date:_____

Address:_____

Cell Phone:_____ Home Phone (if not cell):_____

E-mail:_____ Occupation:_____

Date of Birth:_____ Age:_____ Gender ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed

How did you hear about us?_____

Spouse's Name:_____ How many children do you have?_____

Spouse's Occupation:_____

Emergency Contact:_____

Relationship to Patient:_____ Phone:_____

Primary Care Physician:_____

PATIENT CONDITION

Location of your pain/symptoms:_____

When did symptoms start? _____

How did symptoms start? _____

_____

What type of pain:

❑ Dull Ache ❑ Tightness ❑ Burning
❑ Sharp ❑ Numbness ❑ Tingling
❑ Stabbing ❑ Shooting ❑ Throbbing
❑ Other:_____

Rate your pain on a scale of 0 - 10 (where 0 = No Pain and 10 = Worst Pain Possible)

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5
❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please select symptom intensity:

❑ Minimum ❑ Mild ❑ Moderate
❑ Severe ❑ Unbearable

Duration of pain:

❑ Constant ❑ Frequent ❑ Occasional
❑ Intermittent

What makes it better: _____

What makes it worse: _____

Do your symptoms radiate? ❑ YES ❑ NO

If so, where? _____

Are symptoms worse in the morning? ❑ YES ❑ NO

Is there a position that is more comfortable/reduces your symptoms?

❑ Bending forward ❑ Extending back
❑ Leaning left ❑ Leaning right
❑ Other:_____

Do you have any Xray and/or MRI results? ❑ Yes ❑ No

*If yes, please bring in a copy of your report and/or CD to your appointment.

Do you have any diagnosed spinal condition? If yes, please list

_____

Do you have any of the following? (check all that apply)

❑ Bone Disease/Compromise ❑ Pregnant
❑ Recent surgery of any kind ❑ Hernia
❑ Severe Central Low Back Pain ❑ Spinal Stimulator
❑ Back/Neck Surgery ❑ Plates/Rods/Cages
❑ Bone Fusion ❑ Metal Plate Fusion
❑ Disc Degeneration ❑ Pain much worse at night

What have you tried that makes the symptoms better?

❑ Medication ❑ Physical Therapy
❑ Surgery ❑ Chiropractic
❑ Massage Therapy ❑ Acupuncture
❑ Other:_____

List any surgeries, traumas, and/or hospitalizations (with approx. dates):

_____

_____

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PAST MEDICAL HISTORY

Past/Current Conditions

- ❑ Osteoporosis
- ❑ Degenerative Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Heart Attack/Heart Disorder
- ❑ Sinus Problems
- ❑ Born with bone/Joint disorder
- ❑ Anxiety/ Depression
- ❑ Headaches/Migraines
- ❑ History Stroke/Aneurysm
- ❑ Cancer
- ❑ Diabetes
- ❑ Autoimmune Disease
- ❑ Dizziness/Vertigo
- ❑ Sleeping Trouble
- ❑ Asthma/ Breathing Problem
- ❑ Digestive Trouble
- ❑ Heartburn/Acid Reflux
- ❑ Menstrual Problems
- ❑ Thyroid/Hormone Disorder
- ❑ High Blood Pressure
- ❑ Convulsions/Epilepsy
- ❑ Prostate Problems
- ❑ Fibromyalgia
- ❑ Neurological Disorder

OTHER:_____

Family Health History (check any that apply):

- ❑ Auto-immune
- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid
- ❑ Heart disease
- ❑ Hypertension
- ❑ Stroke

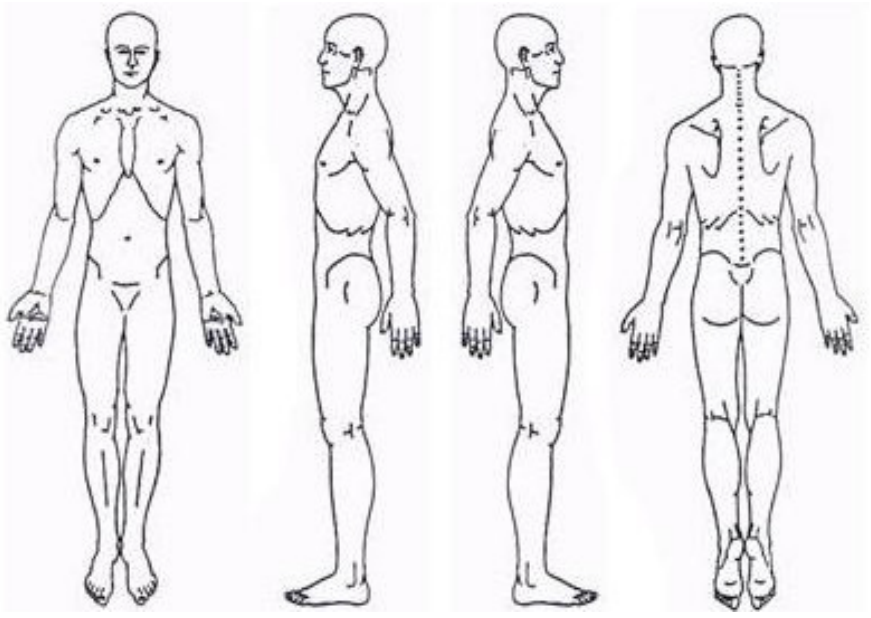
PATIENT PAIN DIAGRAM

Click area(s) of diagram to display painful/symptom location.

Please mark off the areas of your complaint(s) on the diagram. Use the following symbols of the pain diagram to accurately describe your condition.

PPP	Pain
NNN	Numbness
TTT	Tingling
BBB	Burning
CCC	Cramping

To be completed in office at the time of your appointment



Patient Signature

Date