Daley Chiropractic New Patient Intake Questionnaire

Name: _____ **Today's Date:** _____

Reason For Visit:

❑ Pain Symptoms ❑ Wellness Visit ❑ Auto Accident
❑ Work Related Injury ❑ Sports Injury ❑ Other Injury

Date of Injury: _____

❑ **Auto Accident:**

❑ Driver ❑ Passenger, Front ❑ Passenger, Rear ❑ Pedestrian

Were You Wearing Seat Belt? ❑Yes ❑No Did You Receive Aid at Scene? ❑Yes ❑No
Is there a Police Report? ❑Yes ❑No Were You Taken to Hospital? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Type of Car? _____ Year? _____ Was the Car Driveable? ❑Yes ❑No

Did You Hit? ❑Air Bag ❑Steering Wheel ❑Side Door ❑Dashboard ❑Windshield

Describe the Accident: _____

_____

_____

❑ **Work Related Injury:**

Job Title: _____ Company: _____ How long? _____

Describe Your Normal Work Activities: _____

Did You File a Report? ❑Yes ❑No Were You Taken to Hospital? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Explain in Detail What Caused the Injury: _____

_____

_____

❑ **Sports or Other Injury:**

Explain in Detail What Caused the Injury: _____

_____

_____

Where Did the Injury Occur? _____

Did You File a Report? ❑Yes ❑No Were You Taken to Hospital? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Primary Symptoms: (Check all that apply)

☐ Headache	☐ Migraines	☐ Neck Pain	☐ Neck Stiffness	☐ Shoulder Pain
☐ Arm Pain	☐ Low Back Pain	☐ Hip Pain	☐ Leg Pain	☐ Back Pain
☐ Soreness	☐ Discomfort	☐ Numbness	☐ Tingling	☐ Dizziness
☐ Fatigue	☐ Weakness	☐ Memory Loss	☐ Hearing Loss	☐ Depressed
☐ Elbow Pain	☐ Knee Pain	☐ Fever	☐ Sweating	☐ Sleep Problems

☐ Other: _____

Additional Symptoms: _____

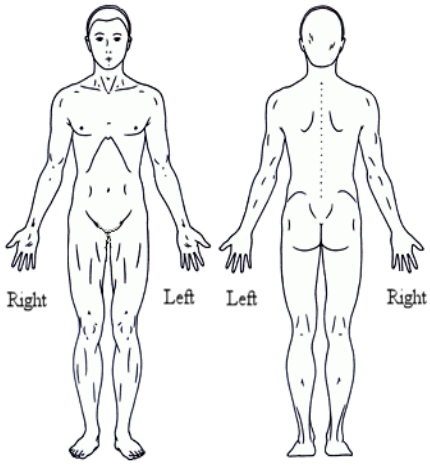
_____

Where Specifically Does it Hurt? (Check all that apply)

☐ Neck	☐ Upper Back	☐ Mid Back	☐ Lower Back	☐ Left Hip	☐ Right Hip
☐ Left Shoulder	☐ Right Shoulder	☐ Left Arm	☐ Right Arm	☐ Left Elbow	☐ Right Elbow
☐ Left Leg	☐ Right Leg	☐ Left Knee	☐ Right Knee	☐ Left Ankle	☐ Right Ankle
☐ Head	☐ Eyes	☐ Ears	☐ Chest	☐ Abdomen	☐ Buttocks

☐ Other: _____

Please Describe the Pain and Place an "X" on the Picture:



Severity:

☐ Mild ☐ Mild-to-Mod ☐ Moderate ☐ Mod-to-Severe ☐ Severe

Frequency:

☐ Once ☐ Intermittent ☐ Occasional ☐ Frequent ☐ Constant

Quality:

☐ Dull ☐ Medium ☐ Sharp ☐ Stabbing ☐ Burning

The Pain is worse: (Check all that apply)

☐ Morning ☐ Midday ☐ After Work ☐ Evening ☐ Nighttime

Describe on a Scale of 1 (mild) to 10 (severe) How You Feel:

Circle One: 1 2 3 4 5 6 7 8 9 10

Have you Been Treated for this Current Condition in the Past?

❑ Yes ❑ No When? _____ By Whom? _____

What Activities of Daily Living are you unable to perform due to your pain?

☐ Sleeping	☐ Walking	☐ Standing	☐ Sitting	☐ Running	☐ Climbing
☐ Bathing	☐ Showering	☐ Dressing	☐ Shoes	☐ Toileting	☐ Cleaning
☐ Self Care	☐ Family Care	☐ Child Care	☐ Home Care	☐ Driving	☐ Gardening
☐ Working	☐ Lifting	☐ Desk Work	☐ Traveling	☐ School	☐ Concentrate

Describe how the pain affects these Activities of Daily Living:

_____

Check the box that describes the pain and Activities of Daily Living (ADL):

1 – No Pain	**2 –** Slight Discomfort	**3 –** Pain with No Effect on ADL's	**4 –** Pain with a Little Effect on ADL's	**5 –** Pain Prevents Any ADL's	**6 –** Pain Limits Work and Prevents Any ADL's	**7 –** Pain Prevents Both Work and ADL's	**8 –** Pain Prevents Working, ADL's and Activity	**9 –** Pain Keeps Me in Bed or Sitting at All Times	**10 –** Pain is Horrible, Cannot Tolerate Movement

Which hand is dominant? □ Right □ Left How old is your current mattress? _____
What type of bed do you sleep on? □ Regular □ Firm □ Water (full wave) □ Water (waveless)
What positions do you sleep in? □ back □ right side □ left side □ stomach □ floor □ chair
Previous chiropractor? Dr. _____ Last visit & reason _____
Family doctor? Dr. _____ Last visit & reason _____
Other physicians seen or tests performed concerning your main complaint:
□ Orthopedic □ Osteopath □ Physical Therapy □ Neurologist □ Podiatrist □ Dentist □ OB/GYN □ MRI □ Xrays
□ CAT Scan □ Nerve Conduction □ Homeopathy □ Massage Therapist □ Other Chiropractor

ADDITIONAL COMPLAINTS: _____

_____

PAST HISTORY:

What other conditions have you been treated for? (Explain in detail)

_____

_____

What Surgeries or Procedures have you had? (Explain in detail)

_____

Medical History – (Check all that apply)

You:

□ Diabetes	□ Arthritis	□ AIDS	□ Sciatica	□ Bursitis	□ Osteoporosis
□ Alzheimer	□ Kidney Dis.	□ Gout	□ Amputation	□ Ulcers	□ High Blood Pressure
□ Cancer	□ Heart Attack	□ Stroke	□ COPD	□ Scoliosis	□ Low Blood Pressure
□ Ulcers	□ Deafness	□ Blindness	□ Migraines	□ Disc Disorder	□ Neuralgia
□ Constipation	□ Diarrhea	□ Nausea	□ Vomiting	□ Varicose Vein	□ Convulsions
□ Fainting	□ Sweats	□ Chills	□ Nervousness	□ Eczema	□ Prostate Trouble
□ Bleeding	□ Tonsillitis	□ Earache	□ Hemorrhoids	□ Pregnancy	□ Neuro-Muscular Disease

□ Other: (Be specific) _____

Your Family:

_____

List any Current Allergies: (Be specific)

_____

Current Medications You are Taking: (Be specific)

_____

Social Activities:

□ Smoke Cigarettes ____ # packs per day □ Smoke Cigars □ I don't smoke
□ Drink Alcohol Beverages ___ # per day, or ___ # per week □ I don't drink alcohol.
□ Beer □ Wine □ Mixed Drinks
□ I admit to history of Recreational Drug Use. □ I deny history of Recreational Drug Use.
□ I am currently Pregnant. Due Date: _____
□ I exercise regularly.
□ I experience frequent stress.

Comments: _____

_____ _____
(Your Signature) (Date) Dr. Michael P. Daley, DC (Date)