SUBJECTIVE INTAKE FORM

Date: ________________  Age: ______

Are you currently receiving?  □ HOME CARE  □ Chiropractic Care
If you check one of the above boxes, please stop filling out this form and consult with a Patient Services Representative.

Organization Name: ___________________________ Date Services Started: ______________

TELL US ABOUT YOUR INJURY OR SYMPTOMS

What is your primary complaint (why you are here): __________________________________________
__________________________________________________________________________________

When did your symptoms start: __________

How did this injury/illness occur: ________________________________________________________
___________________________________________________________________________________

How much do your symptoms interfere with your usual daily activities?

☐ Not at all  ☐ A little  ☐ Moderately  ☐ Quite a bit  ☐ Extremely

Pain Scale: (0-10) Present : ______ (0-10) Worst ______ (0-10 ) Best: _________

Date of next doctor’s appt.: ________________

Have you received therapy for this condition before?  ☐ Yes  ☐ No

Explain: ___________________________________________________________________________
__________________________________________________________________________________

* Place X’s for any areas of tingling or numbness
* Shade in area of your pain

*HCH2354*
SUBJECTIVE INTAKE FORM

DIAGNOSTIC IMAGING  Have you had a recent Imaging test for your injury or symptoms:
☐ None  ☐ X-Rays  ☐ CT Scan  ☐ MRI  ☐ LAB TESTS
Results:___________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

TELL US ABOUT YOU

LIVING ENVIRONMENT:  I live:  ☐ Alone  ☐ With family, spouse, partner  ☐ Other:__________
Do you have stairs to get into your home?  ☐ YES  How many? _____  ☐ NO
Do your stairs have rails?  ☐ YES  ☐ NO
Do you have stairs inside your home?  ☐ YES  How many? _____  ☐ NO
Do your stairs have rails?  ☐ YES  ☐ NO

WORK ENVIRONMENT:  Are you presently working?  ☐YES  ☐NO
What is your job/occupation? ________________________________________________________
What kinds of activities do you perform at work? ______________________________________
Do you use any special supports (brace, corset, cushions, etc.)?  ☐YES  ☐NO
Explain: __________________________________________________________________________

LEARNING STYLES:  What is your preferred method of learning (check all that applies)?
☐ Verbal  ☐ Visual  ☐ Demonstration
Do you have any barriers to learning?  ☐YES  ☐NO  If yes, please explain: _________________
______________________________________________________________________________
______________________________________________________________________________

PRIOR LEVEL OF FUNCTION

Activities of Daily Living (bathing, dressing, meal prep):  ☐ Independent
☐ Independent with extra time  ☐ Requires Assistance  ☐ Unable to Perform
Other: __________________________________________________________________________

Work Activities:  ☐ Independent  ☐ Independent with extra time  ☐ Requires Assistance
☐ Unable to Perform
Other: __________________________________________________________________________

Recreational Activities:

Work Activities:  ☐ Independent  ☐ Independent with extra time  ☐ Requires Assistance
☐ Unable to Perform
Other: __________________________________________________________________________

Do you use an assistive device?  ☐YES  ☐NO  Explain: ________________________________
TELL US ABOUT YOUR MEDICAL HISTORY:

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<thead>
<tr>
<th>Medical History</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
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<tbody>
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<td><strong>CARDIAC</strong></td>
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<tr>
<td>Angina/Chest Pain</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Heart Attack</td>
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<tr>
<td>Heart Disease</td>
<td>No</td>
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<tr>
<td>Heart Palpitations</td>
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<tr>
<td>High Cholesterol</td>
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<tr>
<td>High Blood Pressure</td>
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<td>Pacemaker</td>
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<tr>
<td><strong>MUSCULOSKELETAL</strong></td>
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<tr>
<td>Osteoporosis</td>
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<tr>
<td>Fractures/Broken bones</td>
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<tr>
<td>Rheumatoid Arthritis</td>
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<td>Yes</td>
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<tr>
<td>Osteoarthritis</td>
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<td><strong>RESPIRATORY</strong></td>
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<tr>
<td>Skin Abnormalities</td>
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<tr>
<td>Rash</td>
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<td>Non Healing Wounds</td>
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<td>Diabetes</td>
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<td><strong>NEUROLOGICAL CONDITIONS</strong></td>
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<td>Kidney Stones/Disease</td>
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<td>Liver/Gallbladder problems</td>
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<td>Thyroid problems</td>
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<td>Anxiety/Panic Attacks</td>
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<td>Depression</td>
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<td>Eating Disorders</td>
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<td><strong>OTHER</strong></td>
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<td>Ulcers/Stomach Disease</td>
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<td>Bleeding Disorder</td>
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<td><strong>CANCER</strong></td>
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<tr>
<td>Bowel/Bladder problems</td>
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<td>Night pain</td>
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<tr>
<td>Nausea/Vomiting</td>
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<tr>
<td>Unexpected weight loss/gain</td>
<td>No</td>
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</table>

Other: ________________________________________________________________
SUBJECTIVE INTAKE FORM

MEDICAL HISTORY (Continued):
Please explain any of the checked items:
________________________________________________________________________________
_________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

For Men: Have you been diagnosed with prostate disease? □ Yes □ No

For Women: Are you pregnant or do you think that you might be pregnant? □ Yes □ No

ALLERGIES □ No Known Allergies
□ Environmental List: _____________________________________________________________
□ Medicine List: _________________________________________________________________

MEDICATIONS
Please list any medications you are presently taking or have recently stopped: _______________
________________________________________________________________________________
________________________________________________________________________________

SURGICAL HISTORY:
Have you ever had surgery? YES/NO If yes, please list, with approximate dates:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Is there anything else you think is important about your condition that we haven’t covered?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
SUBJECTIVE INTAKE FORM

TELL US ABOUT YOUR GENERAL HEALTH

Do you smoke or chew tobacco?  ☐ YES  How much? ________For how long? ________  ☐ NO

Have you had any unexplained weight gain or loss in the last month?  ☐ YES  ☐ NO

Do you have difficulty with:  Hearing:  ☐ YES  ☐ NO  Do you wear Hearing Aids?  ☐ YES  ☐ NO

Vision:  ☐ YES  ☐ NO  Do you wear Glasses/Contacts  ☐ YES  ☐ NO

What type of activities, exercise, and/or sports do you participate in?  ____________________________
________________________________________________________________________________

Do you have trouble sleeping at night?  ☐ YES  ☐ NO  If yes, explain: ____________________________
________________________________________________________________________________

DO YOU HAVE A HISTORY OF FALLS  ☐ YES (check what best applies)  ☐ NO

☐ I have fallen recently (within the past month)
☐ I fall frequently (more than twice over the past 6 months)
☐ I have fallen in the past year
☐ I have almost fallen due to losing my balance

☐ The Fall Screen was performed and the patient’s Fall Risk was appropriately assessed.

The above information has been reviewed and discussed by the patient and the therapist.

_______________________________________________   __________
Patient Signature            Date / Time

______________________________________________   __________
Therapist Signature        Date / Time