

Today's Date: _____



Adult Intake Assessment

***Please answer all questions as accurately and thoroughly as possible. Although some questions may not be applicable to you, there is a specific reason behind each question. This information will remain confidential at all times.**

General Information:

Patient's Name: _____ Date of Birth: ___ / ___ / ___ Age: _____

Referring Physician's Name: _____

How did you hear about us?: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phones (please check box for best contact number):

Home: _____ Work: _____ Cell: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Name of your Insurance Carrier: _____

Current Medical Condition:

What started off your problem(s)?: _____

When did these symptoms first occur (Date if possible)?: _____

If these symptoms are the result of an injury/accident, describe what happened: _____

How have symptoms changed since the onset?: _____

What do you do to help control the pain or dysfunction?: _____

What aggravates your symptoms?: _____

What special tests have you had for this condition?: _____

- | | | |
|------------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> EMG | <input type="checkbox"/> X – Ray |
| <input type="checkbox"/> CAT Scan | <input type="checkbox"/> Injections | |
| <input type="checkbox"/> Discogram | <input type="checkbox"/> MRI | |

Have you ever had previous treatment for this condition?: Yes No

If yes, what type and when?: _____

Medical History:

Hospitalizations/Surgeries: _____

Previous trauma(s) or car accident(s): _____

Other health problems: _____

Current medications: _____

Do you use any special medical equipment for daily activities, such as glasses/contacts, orthotics, heel lifts, cane, etc.? _____

Today's Date: _____


Symptom Survey (check all that apply):

- Blurred vision
- Difficulty opening or closing mouth
- Fullness in ears
- Headache
- Jaw Pain or Popping
- Problems sitting
- Problems Standing
- Ringing in Ears
- Vertigo/Dizziness


If headaches apply, please list frequency, duration, and location: _____
Using the key below, indicate on the chart(s) the appropriate symptom(s) and area(s) where you are having the most pain.

X = Sharp Sensations
O = Numbness or Tingling
= Dull Aching
+ = Burning Sensations

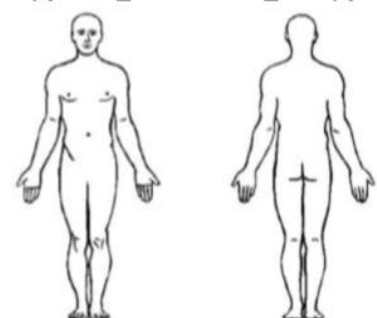
L R



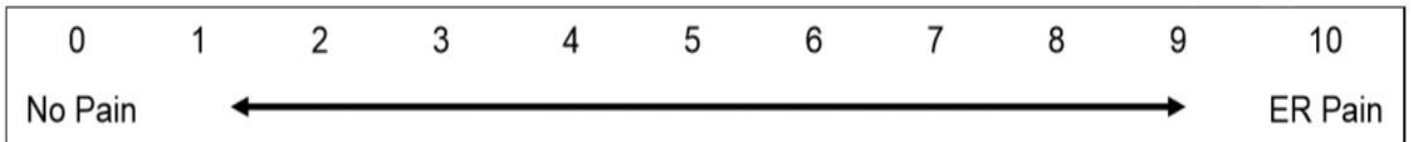
L R



R L L R



If you have pain, fill in the blanks with the appropriate number according to the scale below:



Pain Level Today: _____ **Pain at Worst:** _____ **Pain at Lowest:** _____

Lifestyle Habit Patterns:

Do you sleep well?: _____ Usual hours/night sleep: _____ Position you sleep in most: _____
 Do you exercise regularly?: _____ If so, what type?: _____
 How many glasses of water do you drink each day?: _____

BACKGROUND INFORMATION

Are you currently employed? Yes No If yes, where? _____
 What type of work do you do? _____
 Have you missed any work because of this condition? _____ If yes, how much? _____
 How have the current symptoms interfered with any work related sports, and or recreational activities?: _____
 Do you have children? _____ If so, what ages? _____

Patient/Family Concerns and Goals

Please describe your major concerns and/or goals with seeking treatment. List them in order of importance to you

- 1: _____
- 2: _____
- 3: _____
- 4: _____