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?:_____________________________________

☐ Bone Scan ☐ EMG ☐ X – Ray
☐ CAT Scan ☐ Injections
☐ Discogram ☐ 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:

0	1	2	3	4	5	6	7	8	9	10
No Pain	←								→	ER Pain

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: ______________________________________ 3:______________________________________

2:______________________________________ 4:______________________________________