REGISTRATION

Date: _____ Phone: _____

Patient: _____

Last Name First Name Middle Initial

Street Address: _____

City/State/Zip: _____

Email: _____

Sex: ☐ Male ☐ Female Age: ____ Birthdate: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

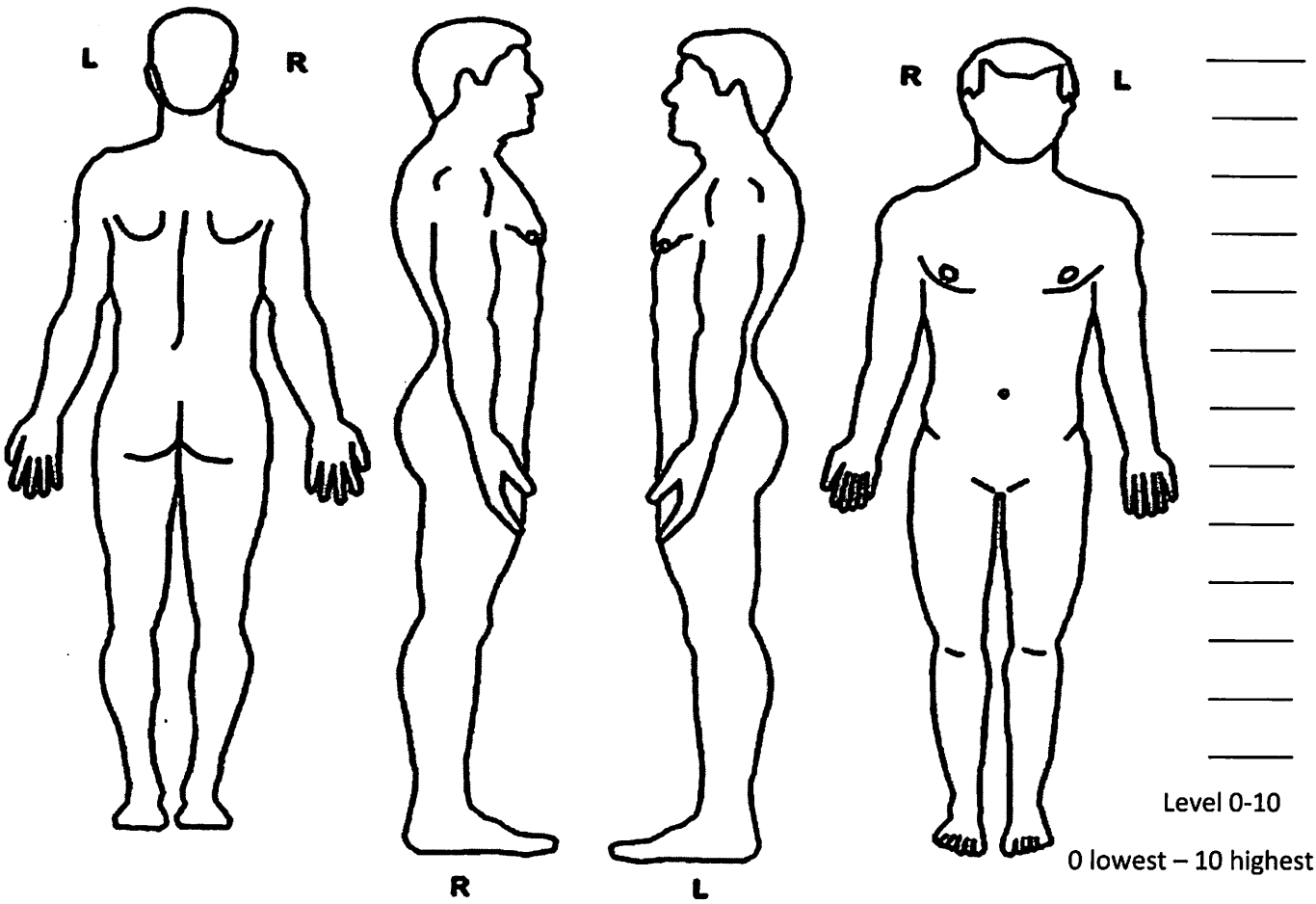
Occupation: _____

Primary Medical Doctor Name: _____ Phone: _____

Pain Drawing

Name: _____

Date: _____



Mark as follows:

A – Ache B – Burning N – Numbness P – Pins & Needles S – Stabbing

O – Other, describe : _____

Patel Clinic of Chiropractic & Sports Medicine

5641 Poplar Tent Rd. Suite 202
Concord, NC 28027
704-782-3421

Name: _____ Date: _____

List your health concerns from *greatest* to the *least* starting from *Column #1*

Current Complaints	1. _____ Left Right Both	2. _____ Left Right Both	3. _____ Left Right Both	4. _____ Left Right Both
Check **all** that apply that describes the quality of your complaint.	Dull Achy Numb Sharp Throbbing Electric/Shooting Restricted Other: _____	Dull Achy Numb Sharp Throbbing Electric/Shooting Restricted Other: _____	Dull Achy Numb Sharp Throbbing Electric/Shooting Restricted Other: _____	Dull Achy Numb Sharp Throbbing Electric/Shooting Restricted Other: _____
If this pain travels or spreads, what area(s) are effected?	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
How often do you feel this complaint?	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional
How long has this been a problem?	_____ _____	_____ _____	_____ _____	_____ _____
Is this getting Better, Worse, or staying the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What makes your pain worse?	_____ _____	_____ _____	_____ _____	_____ _____
What gives you some relief?	_____ _____	_____ _____	_____ _____	_____ _____
Rate this problem on 0-10 scale	0 1 2 3 4 5 6 7 8 9 10 0 = No pain 10= Excruciating	0 1 2 3 4 5 6 7 8 9 10 0 = No pain 10= Excruciating	0 1 2 3 4 5 6 7 8 9 10 0 = No pain 10= Excruciating	0 1 2 3 4 5 6 7 8 9 10 0 = No pain 10= Excruciating
What have you done to take care of this complaint?	_____ _____	_____ _____	_____ _____	_____ _____
Did it work?	Yes Partially No Slightly	Yes Partially No Slightly	Yes Partially No Slightly	Yes Partially No Slightly
This is effecting my:	Work Cooking Sleep Cleaning Self-Care Dishes Yard Work Gardening Home Maintenance Hobbies	Work Cooking Sleep Cleaning Self-Care Dishes Yard Work Gardening Home Maintenance Hobbies	Work Cooking Sleep Cleaning Self-Care Dishes Yard Work Gardening Home Maintenance Hobbies	Work Cooking Sleep Cleaning Self-Care Dishes Yard Work Gardening Home Maintenance Hobbies

Additional Notes: _____
_____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Intake Form

Patient Name: _____ Date: _____

1. Who else have you seen for your problem? (circle all that apply)

   Chiropractor Neurologist Primary Care Physician
   ER Physician Orthopedist Massage Therapist
   Physical Therapist No One Other:_____

2. How would you rate your overall health? (circle one)

   Excellent Very Good Good Fair Poor

3. What type of exercise do you do?

   Strenuous Moderate Light None

4. Circle if you have any immediate family members with any of the following:

   Rheumatoid Arthritis Diabetes Cancer
   Heart Problems Lupus ALS

5. For each of the conditions mentioned please mark if you have had in the PAST or PRESENT in the correct column.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT
☐	☐ Headaches		☐	☐ High Blood Pressure		☐	☐ Diabetes
☐	☐ Neck Pain		☐	☐ Heart Attack		☐	☐ Excessive Thirst
☐	☐ Upper back Pain		☐	☐ Chest Pain		☐	☐ Frequent Urination
☐	☐ Mid Back Pain		☐	☐ Stroke		☐	☐ Smoking/Tobacco
☐	☐ Low Back Pain		☐	☐ Angina		☐	☐ Drug/Alcohol Abuse
☐	☐ Shoulder Pain		☐	☐ Kidney Stones		☐	☐ Allergies
☐	☐ Elbow/Upper arm		☐	☐ Kidney Disorders		☐	☐ Depression
☐	☐ Wrist pain		☐	☐ Bladder Infections		☐	☐ Systematic Lupus
☐	☐ Hand Pain		☐	☐ Painful Urination		☐	☐ Epilepsy
☐	☐ Hip Pain		☐	☐ Loss of Bladder Control		☐	☐ Eczema/Rashes

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT
☐	☐ Upper leg Pain		☐	☐ Prostate Problems		☐	☐ HIV/AIDS
☐	☐ Knee Pain		☐	☐ Abnormal Weigh Changes		☐	☐ Asthma
☐	☐ Ankle/Foot Pain		☐	☐ Loss of Appetite		☐	☐ Ulcer
☐	☐ Jaw Pain		☐	☐ Abdominal Pain		☐	☐ Hepatitis
☐	☐ Joint Pain/Stiffness		☐	☐ Arthritis		☐	☐ Rheumatoid Arthritis
☐	☐ Cancer		☐	☐ Tumor			
☐	☐ Chronic Sinusitis		☐	☐ Liver/Gall Bladder Disorder			
☐	☐ General Fatigue		☐	☐ Muscular Incoordination			
☐	☐ Visual Disturbances		☐	☐ Dizziness		☐	☐ Other: _____

For Females Only:

PAST	PRESENT
☐	☐ **Birth Control**
☐	☐ Hormone Replacement
☐	☐Pregnancy

6. List all **prescription** medication you are currently taking:

_____

_____

7. List all of the **over the counter medications or supplements** you are taking:

_____

_____

8. List all the **surgical procedures** you have had:

_____

_____

9. What activities do you do at work?

☐ Sit	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Stand	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Computer work	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ On the phone	☐ Most of the day	☐ Half of the day	☐ A little of the day

10. What activities do you do outside of work?

_____

11. What hobbies do you do outside of work?

_____

12. Have you ever been hospitalized? ☐ NO ☐ Yes

If yes, why: _____

13. Have you had significant past trauma? ☐ NO ☐ Yes

If yes, what: _____

Patient Name: _____ Date: _____