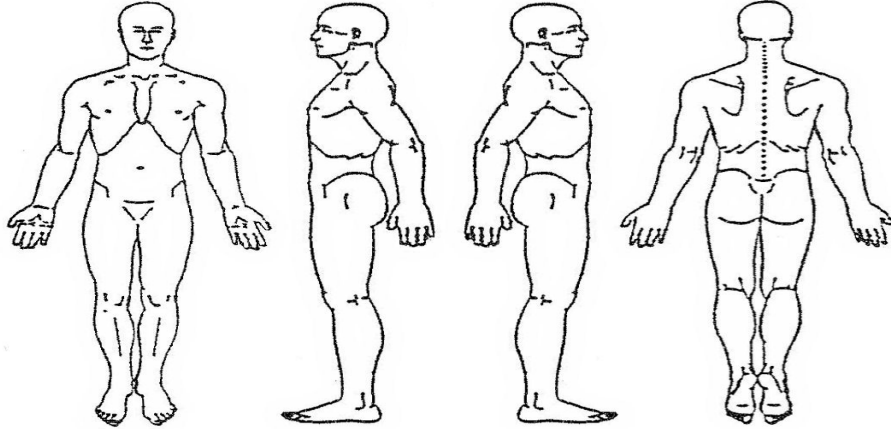


PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation Other

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

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

8. How much has the problem interfered with your social activities?

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

9. Other Doctor seen for this condition?

10. How long have you had this problem? _____

11. How do you think your problem began?

12. What aggravates your problem?

13. What concerns you the most about your problem; what does it prevent you from doing?

14. What is your: Height _____ Weight _____ Date of Birth _____
Occupation _____

15. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

Patient Personal/Confidential Information

Date _____

Patient Name _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home/Cell Phone _____ Work Phone _____

SS No. _____ E-mail _____

Occupation _____

Employer/Address _____

Name of Spouse _____ Spouse's SS No. _____ No. of Children _____

Spouse's Employer/Address _____

Emergency Contact _____ Phone _____

Who is responsible for payment? Self Spouse Other _____

How did you learn of this clinic? _____

What is your major complaint? _____

Patient's Insurance

Name of Company _____

Address _____

ID & Group No. _____

Phone No. _____

Spouse's Insurance

Name of Company _____

Address _____

ID & Group No. _____

Phone No. _____

Financial Office Policy

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Flores Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Flores Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____