



# MESSINA FAMILY CHIROPRACTIC

## New Patient Intake Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Have you ever been to another doctor for this problem? Y N Who? \_\_\_\_\_  
 Who referred you to this office? \_\_\_\_\_

### What Brings You To Our Office

**FIRST COMPLAINT:** \_\_\_\_\_

- Date when symptom first appeared \_\_\_\_\_
- Did it begin \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_ Progressive over time
- What makes the symptoms increase? \_\_\_\_\_
- What relieves the symptoms? \_\_\_\_\_
- Type of Pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burn \_\_\_\_\_ Throb
- Does the Pain Radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate
- Do you experience Numbness or Tingling? \_\_\_\_\_ Y \_\_\_\_\_ N
- How often do you experience these symptoms?  
 \_\_\_\_\_ 100% \_\_\_\_\_ 75% \_\_\_\_\_ 50% \_\_\_\_\_ 25% \_\_\_\_\_ 10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

No Pain \_\_\_\_\_ Unbearable Pain

**OTHER COMPLAINT:** \_\_\_\_\_

- Date when symptom first appeared \_\_\_\_\_
- Did it begin \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_ Progressive over time
- What makes the symptoms increase? \_\_\_\_\_
- What relieves the symptoms? \_\_\_\_\_
- Type of Pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burn \_\_\_\_\_ Throb
- Does the Pain Radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate
- Do you experience Numbness or Tingling? \_\_\_\_\_ Y \_\_\_\_\_ N
- How often do you experience these symptoms?  
 \_\_\_\_\_ 100% \_\_\_\_\_ 75% \_\_\_\_\_ 50% \_\_\_\_\_ 25% \_\_\_\_\_ 10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

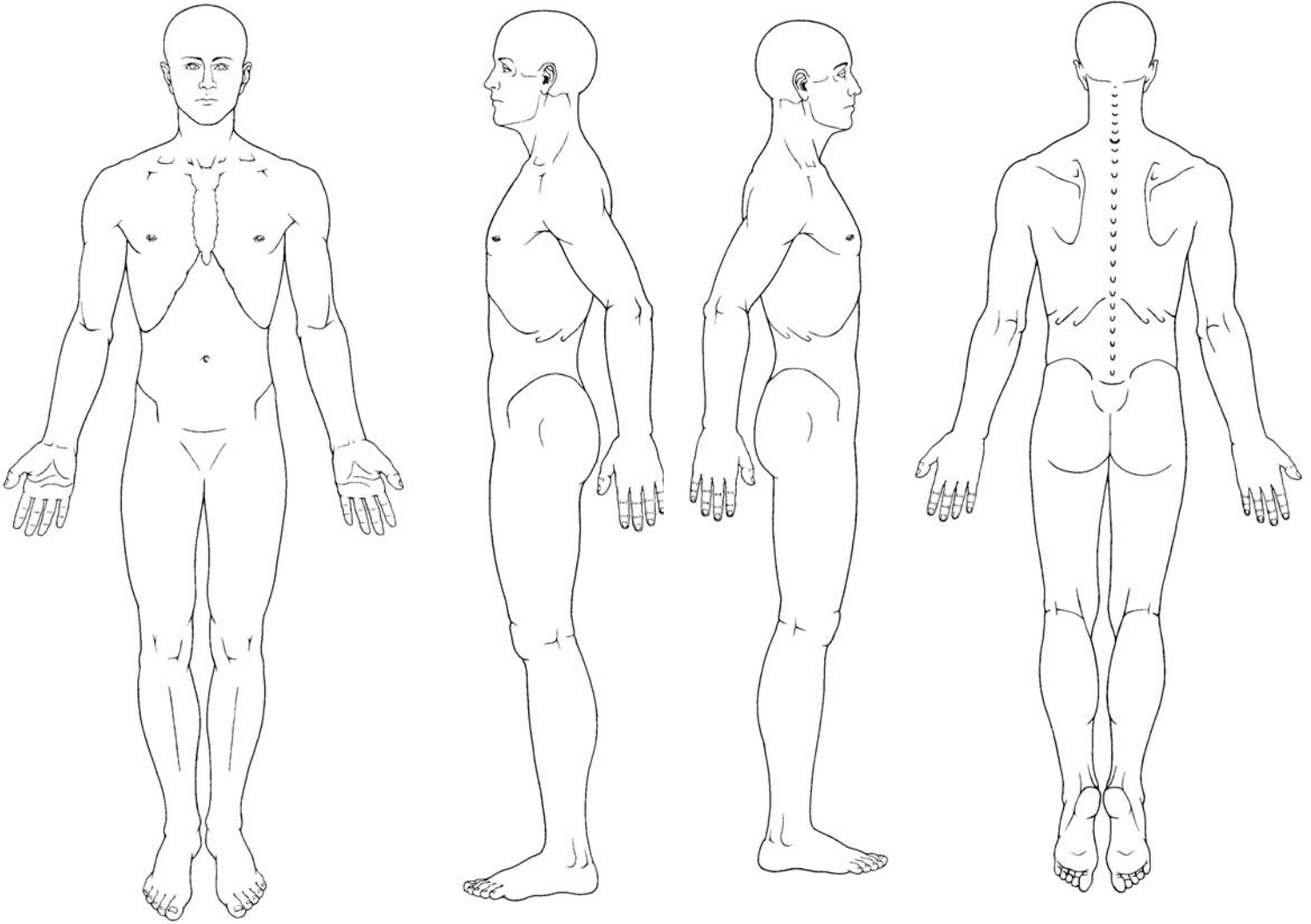
No Pain \_\_\_\_\_ Unbearable Pain

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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## PAIN LOCATION



**Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.**

- |            |                                      |
|------------|--------------------------------------|
| <b>PPP</b> | <b>Where you experience Pain</b>     |
| <b>NNN</b> | <b>Where you experience Numbness</b> |
| <b>TTT</b> | <b>Where you experience Tingling</b> |
| <b>BBB</b> | <b>Where you experience Burning</b>  |
| <b>CCC</b> | <b>Where you experience Cramping</b> |

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

