

Intake Form

Client Information

Name			Claim Number		
Address			Policy Number		
			Date of Loss		
Telephone			Date of Birth		
Cell/Work			Insurance Company		

Medical Doctor Information

Name			Telephone		
Address			Cell/Work		
			Recommendations		

Legal Representative Information

Firm			Telephone		
Address			Fax		
			Name		

Insurance Information

Company			Telephone		
Address			Fax		
			Adjustor		
Policy Name			Manager		

Work Information

Company					
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Reason for Initial Visit - List Area of Complaint

Dizziness	Hip Pain	Urinary/Bowel Diff.	Elbow Pain
Headaches	Knee Pain	Nausea/Vomiting	Ringings in Ears
Neck Pain	Thigh/Leg Pain	Loss of Sleep	Arm/Forearm Pain
Upper Back Pain	Ankle/Foot Pain	Constant Irritability	Fever
Mid Back Pain	Pins and Needles Arms	Loss of Memory	Infection
Low Back Pain	Pins and Needles Legs	Loss of Balance	Wrist/Hand Pain
Chest Pain	Numbness	Jaw Pain	Shoulder Pain
Rib Pain	Blurred Vision	Depression	Abdominal Pain
Other:			

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Current Pain Diagnosis (Dx) (if seen at another facility)

Dx 1		Dx 6	
Dx 2		Dx 7	
Dx 3		Dx 8	
Dx 4		Dx 9	
Dx 5		Dx 10	

Social History

Marital Status		Employed: Co. Name	
Smoker		Missed Days of Work	
Alcohol		Other work issues	
Caffeine			
Other Drugs			

Past Medical History

Anemia	Tuberculosis	Thyroid Disease	Pace Maker
Hives / Eczema	AIDS/ HIV+	Bleeding Tendency	Infection - Mono
Chicken Pox/Shingles	High or Low Blood Pressure	Hepatitis ____	Birth Defects - List
Glaucoma/Cataracts	Neck Pain	Kidney Disease	Stroke
Pneumonia	Back Pain	Liver Disease	Diabetes I/II
Hernia / Ulcer	Disc Herniation/Bulge	History of Tobacco Usage	Rheumatoid Arthritis
Asthma	Epilepsy	History of Alcohol Usage	Brain Disease
Cancer	Blood/Plasma Transfusion	History of Drug Abuse	Breast Lump
Venereal Disease	Headaches	Recent Infection/Flu	Arthritis
Are you Pregnant			

Current Medications and who Prescribed

Medical	Doctor who Prescribed	Medical	Doctor who Prescribed

Are you able to Drive?

Yes or No	Why:	
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Can you Describe your Pain (Circle)

Achy	Crippling	Itchy	Tension
Acute	Dull	Pressure	Thumping
Agonizing	Excruciating	Sharp	Tight
Angry	Gnawing	Sore	Torturous
Bad	Gripping	Stabbing	Unendurable
Burning	Heavy	Stiff	Vice-Like
Chapped	Inflamed	Stinging	Violent
Chronic	Irritated	Tender	
Other			

Treatments Provided to Date

Injections		Chiropractic	
Medications		Acupuncture	
Nerve Blocks		Physiotherapy	
Psychology		Massage Therapy	
Mindfulness		Multi-Disciplinary	
Other		Other	
Other		Other	

Results of Above Care:

General Pain Questions:

What things make you feel better?

What things make you feel worse?