Garden Lakes Chiropractic, LLC 10720 W Indian School Rd #67, Phoenix, AZ 85037 623-877-0156

PATIENT REGISTRATION

Printed Name: _____ Social Security #: _____

Birthdate: _____ Marital Status (Circle one): M S D W Spouse's Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone No: _____ Work Phone No: _____ **Cell No**: _____

Email: _____ **Cell Phone Carrier**: _____

Whom may we thank for referring you to our office: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's phone #: _____

Insured's Information

Insured's Name: _____ Relationship: _____ Insured's Birthdate: _____

Insured's SS No: _____ Insured's Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Patient communication sheet:

____ ok to call my home and leave a message
____ call my home phone but do not leave messages
____ do not call home phone, call only this number (_____) _____
____ do not speak to family members

I give permission to the following individuals to receive protected health information:

_____ _____ _____

In case of an emergency, notify: _____ Relationship: _____ Phone#: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Patient signature: _____ Date: _____

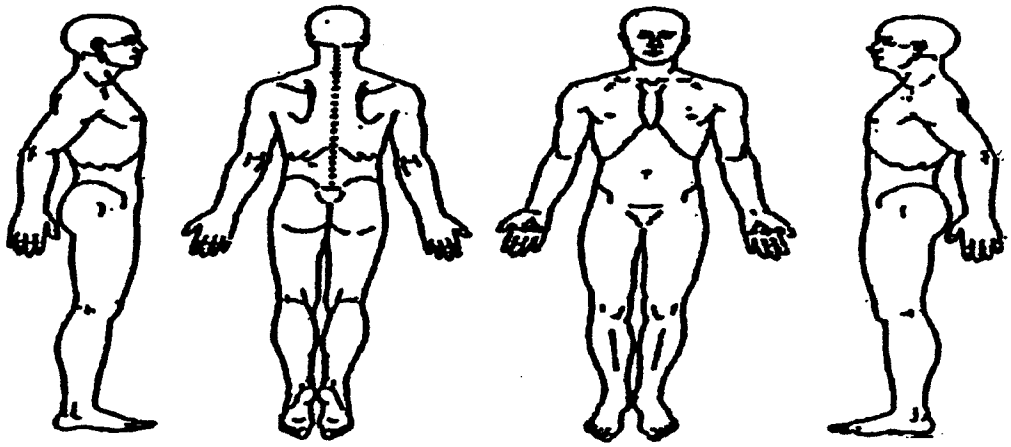
Garden Lakes Chiropractic, LLC 10720 W. Indian School Rd #67, Phoenix, AZ 85037 623-877-0156 Fax: 623-877-4541

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

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

2. Indicate on drawing below your area of complaint.



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

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. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

13. What makes your pain worse? _____

14. What makes your pain better? _____

15. What is your: Height:_____, Weight: _____lbs,

Handedness: Right ___ Left___

Occupation _____, Employer _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. Social History:
□ Single □ Married □ Divorced □ Widowed Number of Children;

□ Alcohol consumption, amount_____ □ Caffeine, Type: Coffee___ Tea___ Soda___

□ Tobacco use, what kind _____ □ Use of recreational drugs, Type_____

Smoking Status?
□ Never Smoker
□ Current every day smoker If so, how many years? _____
□ Current some day smoker If so, how many years? _____
□ Former smoker If so, how many years? _____

Sleep Habits: Approx. how many hours per night? ____, Do you wake up often during the night? Yes___ No___

18. Race? □ I do not wish to provide this information
□ White □ Black or African American □ Native Hawaiian or Other Pacific Islander
□ Asian □ American Indian or Alaska Native □ Other _____

19. Ethnicity? □ I do not wish to provide this information
□ Hispanic or Latino □ Non-Hispanic or Non-Latino □ Other _____

20. Preferred Language? □ English □ Spanish □ Other_____

21. Check all that applies to your medical history;

□ Headaches
□ Neck Pain
□ Upper Back Pain
□ Mid Back Pain
□ Low Back Pain
□ Shoulder Pain
□ Elbow/Upper Arm Pain
□ Wrist Pain
□ Hand Pain
□ Hip Pain
□ Upper Leg Pain
□ Knee Pain
□ Ankle/Foot Pain
□ Jaw Pain
□ Joint Pain/Stiffness
□ Arthritis
□ Rheumatoid Arthritis
□ Cancer
□ Tumor
□ Asthma
□ Chronic Sinusitis
□ High Blood Pressure
□ Heart Attack
□ Chest Pains
□ Stroke
□ Angina
□ Kidney Stones
□ Kidney Disorders
□ Bladder Infection
□ Painful Urination
□ Loss of Bladder Control
□ Prostate Problems
□ Abnormal Weight Gain/Loss
□ Loss of Appetite
□ Abdominal Pain
□ Ulcer
□ Hepatitis
□ Liver/Gall Bladder Disorder
□ General Fatigue
□ Muscular Incoordination
□ Visual Disturbances
□ Dizziness
□ Diabetes
□ Excessive Thirst
□ Frequent Urination
□ Smoking/Tobacco Use
□ Drug/Alcohol Dependence
□ Allergies
□ Depression
□ Systemic Lupus
□ Epilepsy
□ Dermatitis/Eczema/Rash
□ HIV/AIDS

For Females Only
□ Birth Control Pills
□ Hormonal Replacement
□ Currently Pregnant
# of Pregnancies_____
# of Deliveries_____

□ Other:_____

22. Indicate if you have immediate family members with any of the following illnesses: (indicate who has the illness)
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ High Blood Pressure
□ Other_____

23. Do you have any medication allergies?

□ No known medication allergies

□ Yes What? _____

24. Are you currently taking any medications?

□ Not currently prescribed any medications

□ Yes, What? _____ _____dose

_____ _____dose

_____ _____dose

_____ _____dose

_____ _____dose

25. List all of the over-the-counter medications you are currently taking:

_____

26. List all surgical procedures you have had and the year they were performed:

_____ _____

_____ _____

_____ _____

_____ _____

27. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

□ **Other: (describe what you do at work)** _____

_____

_____

28. Have you ever been hospitalized? □ No □ Yes

if yes, why _____

29. Have you had significant past trauma? □ No □ Yes

30. Anything else pertinent to your visit today? _____

Patient Signature _____ **Date:** _____

Pain Disability Questionnaire

Last Name: _____ First Name: _____ MI: ____ Date: _____

Rate the degree to which your symptoms have negatively affected your ability to perform the following functions. Rate each function as follows: 0=not at all, 1-3=slightly, 4-6=moderately, 7-10=severely.

1. Does your pain interfere with your normal work inside and outside the home?
   Work normally — Unable to work at all
   0 1 2 3 4 5 6 7 8 9 10
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of myself completely — Need help with all personal care
   0 1 2 3 4 5 6 7 8 9 10
3. Does your pain interfere with your travelling?
   Travel anywhere I like — Only travel to see doctors
   0 1 2 3 4 5 6 7 8 9 10
4. Does your pain affect your ability to sit or stand?
   No problems — Cannot sit/stand at all
   0 1 2 3 4 5 6 7 8 9 10
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   No problems — Cannot do at all
   0 1 2 3 4 5 6 7 8 9 10
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   No problems — Cannot do at all
   0 1 2 3 4 5 6 7 8 9 10
7. Does your pain affect the ability to walk or run?
   No problems — Cannot walk/run at all
   0 1 2 3 4 5 6 7 8 9 10
8. Has your income declined since your pain began?
   No decline — Lost all income
   0 1 2 3 4 5 6 7 8 9 10
9. Do you have to take pain medication every day to control your pain?
   No medication needed — On pain medication throughout the day
   0 1 2 3 4 5 6 7 8 9 10
10. Does your pain force you to see doctors much more often than before your pain began?
    Never see doctors — See doctors weekly
    0 1 2 3 4 5 6 7 8 9 10
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    No problems — Never see them
    0 1 2 3 4 5 6 7 8 9 10
12. Does your pain interfere with recreational activities and hobbies that are important to you?
    No interference — Total interference
    0 1 2 3 4 5 6 7 8 9 10
13. Do you need help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
    Never need help — Need help all the time
    0 1 2 3 4 5 6 7 8 9 10
14. Do you now feel more depressed, tense, or anxious than before your pain began?
    No depression/tension — Severe depression/tension
    0 1 2 3 4 5 6 7 8 9 10
15. Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?
    No problems — Severe problems
    0 1 2 3 4 5 6 7 8 9 10

Patient Signature: _____ CL#: _____