Marshall County Chiropractic
142 VINE STREET
BENTON, KY 42025

TELEPHONE: (270) 527-0000
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PATIENT INFORMATION UPDATE

Today's Date: _____/_____/_____

Name: _____Marital Status: M____S____W____D____

Mailing Address: _____City: _____ST: _____Zip: _____

Home Phone: (____) _____ Cell Phone (____)_____

Employer:_____Work Phone:_____

Emergency Contact:_____ Relation:_____ Phone:(____)_____

INSURANCE INFORMATION

Policy Holders Name:_____Relationship_____

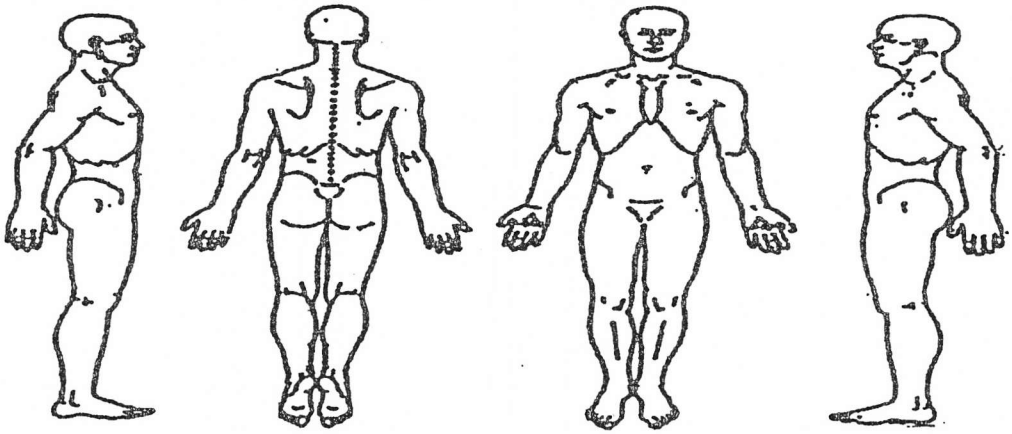
Birthdate:_____/_____/_____Employer:_____

PATIENT INTAKE FORM

Patient Name (please print):_____ Date:_____

Occupation: _____

1. Is today's problem caused by: Auto Accident: Yes No Workman's Compensation: Yes No
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)
   - □ Frequently (51-75% of the time)
   - □ Occasionally (26-50% of the time)
   - □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
   - □ Sharp
   - □ Dull
   - □ Diffuse
   - □ Achy
   - □ Burning
   - □ Shooting
   - □ Stiff
   - □ Numb
   - □ Tingly
   - □ Sharp with motion
   - □ Shooting with motion
   - □ Stabbing with motion
   - □ Electric like with motion
   - □ 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 □ Significantly

8. How much has the problem interfered with your social activities?
   □ Not at all □ A little bit □ Moderately □ Quite a bit □ Significantly

9. Who else have you seen for your problem?
   - □ Chiropractor
   - □ ER physician
   - □ Massage Therapist
   - □ Neurologist
   - □ Orthopedist
   - □ Physical Therapist
   - □ Primary Care Physician
   - □ Other:_____
   - □ 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 gives you relief, or makes problem better?

_____

14. What aggravates your problem?

_____

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

_____

16. What is your: Height_____ Weight _____ Date of Birth _____

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Patient Name (please print):_____Date:_____

17. How would you rate your overall health? □ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following (including grandparents):

□ Rheumatoid Arthritis_____ □ Diabetes _____ □ Lupus_____ Other_____

□ Heart Problems _____ □ Cancer_____ □ ALS_____ Other_____

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

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

21. List all prescription medications you are currently taking (we can copy a list if you have one):

_____

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

_____

23. List all surgical procedures you have had (include dates):

_____

24. 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

25. What activities do you do outside of work?

_____

26. Have you ever been hospitalized? □ No □ Yes
If yes, why/when _____

27. Have you had significant past trauma, broken bones, and/or accidents? □ No □ Yes
If yes, what/when_____

28. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date**_____

----------DO NOT WRITE BELOW THIS LINE----------

Doctor's Notes:_____

_____

_____