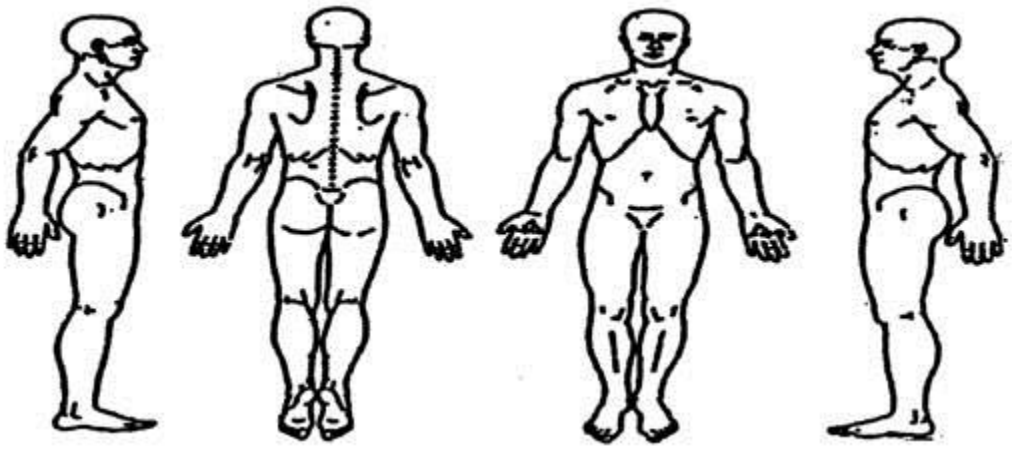
# MCGRAW CHIROPRACTIC LLC
# PATIENT INTAKE FORM

Patient Name: _____ Date: _____

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

**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. 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 aggravates your problem?**

_____

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

_____

**15. What is your: Height_____ Weight _____ Date of Birth _____**
**Occupation _____**

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

**17. What type of exercise do you do?**
□ Stenuous □ Moderate □ Light □ None

**18. Indicate if you have any immediate family members with any of the following:**
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

**19. 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 Dependance |
| □ | □ | 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:_____ | | | | | | |

**20. List all prescription medications you are currently taking:**
_____

**21. List all of the over-the-counter medications you are currently taking:**
_____

**22. List all surgical procedures you have had:**
_____

**23. 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 |

**24. What activities do you do outside of work?**
_____

**25. Have you ever been hospitalized?** □ No □ Yes
if yes, why _____

**26. Have you had significant past trauma?** □ No □ Yes

**27. Anything else pertinent to your visit today?**_____

**Patient Signature**_____ **Date:**_____

**MCGRAW CHIROPRACTIC LLC**

**DR. RYAN McGRAW**

**PATIENT'S NAME** _____ **ID#**_____

**DATE:**_____

## Vertebral Artery Insufficiency Screening.

1. Have you or a family member ever suffered a stroke? **YES OR NO**

2. Have you ever experienced unexplained blurred vision, double vision, or partial loss of vision? **YES OR NO**

3. Have you ever experienced a momentary blackout or unexplained loss of consciousness? **YES OR NO**

4. Have you ever experienced slurred speech or speech problems? **YES OR NO**

5. Have you ever experienced weakness, loss of strength in face, fingers, hands or legs? **YES OR NO**

6. Do you suffer from High blood pressure (Hypertension)? **YES OR NO**

7. Have you ever been diagnosed with any of the following?

____ **Heart Disease**
____ **Atherosclerosis**
____ **Diabetes**
____ **Vascular Anomalieds**

8. Have you had a cardiac related surgery? **YES OR NO**

Left blood pressure_____ Right blood pressure _____

Systolic Difference _____

George's screening procedure - / + _____

Subciavian Bruit

Carotid Bruit

Doctor's Notes:

_____

_____

_____

_____

_____

_____

**Doctor's Signature** _____ **Patient's Signature** _____