

Schauder Chiropractic Care Patient Information Form

Barcode/Z #:

Name: _____ Today's Date: _____

Please complete the Patient Information Form and the Patient Intake Questionnaire. Thank You.

Patient Information:

Full Name: _____ Date of Birth: ____/____/____

Address: _____ Social Sec #: ____ - ____ - ____

City: _____ Home Phone: _____

State: _____ Zip: _____ Cel Phone: _____

Email Address: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone #: _____

Spouse / Parent / Guardian Information:

Full Name: _____ Date of Birth: ____/____/____

Address: _____ Social Sec #: ____ - ____ - ____

City: _____ Home Phone: _____

State: _____ Zip: _____ Cel Phone: _____

Email Address: _____

Employer: _____ Work Phone: _____

Insurance and Primary Care Physician (PCP) Information:

Company: _____ Member/Acct#: _____

Employer: _____ Group #: _____

Member / Policyholder's Name: _____

PCP Name: _____ Phone #: _____

City: _____ State: _____

Please sign this form, and move on to the Patient Intake Questionnaire.

(Your Signature)

(Date)

Patient Intake Questionnaire

Barcode/Z #:

Name: _____ Today's Date: _____

Reason For Visit:

- Pain Symptoms Wellness Visit Auto Accident
 Work Related Injury Sports Injury Other Injury

Date of Injury: _____

Auto Accident:

- Driver Passenger, Front Passenger, Rear Pedestrian

Were You Wearing Seat Belt? Yes No Did You Receive Aid at Scene? Yes No
Is there a Police Report? Yes No Were You Taken to Hospital? Yes No
Did You See Your PCP? Yes No

Type of Car? _____ Year? _____ Was the Car Driveable? Yes No

Did You Hit? Air Bag Steering Wheel Side Door Dashboard Windshield

Describe the Accident: _____

Work Related Injury:

Job Title: _____ Company: _____ How long? _____

Describe Your Normal Work Activities: _____

Did You File a Report? Yes No Were You Taken to Hospital? Yes No
Did You See Your PCP? Yes No

Explain in Detail What Caused the Injury: _____

Sports or Other Injury:

Explain in Detail What Caused the Injury: _____

Where Did the Injury Occur? _____

Did You File a Report? Yes No Were You Taken to Hospital? Yes No
Did You See Your PCP? Yes No

Primary Symptoms: (Check all that apply)

- | | | | | |
|-------------------------------------|--|--------------------------------------|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Migraines | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Soreness | <input type="checkbox"/> Discomfort | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weakness | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Fever | <input type="checkbox"/> Sweating | <input type="checkbox"/> Sleep Problems |
- Other: _____

Additional Symptoms: _____

Where Specifically Does it Hurt? (Check all that apply)

- | | | | | | |
|--|---|------------------------------------|-------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Left Hip | <input type="checkbox"/> Right Hip |
| <input type="checkbox"/> Left Shoulder | <input type="checkbox"/> Right Shoulder | <input type="checkbox"/> Left Arm | <input type="checkbox"/> Right Arm | <input type="checkbox"/> Left Elbow | <input type="checkbox"/> Right Elbow |
| <input type="checkbox"/> Left Leg | <input type="checkbox"/> Right Leg | <input type="checkbox"/> Left Knee | <input type="checkbox"/> Right Knee | <input type="checkbox"/> Left Ankle | <input type="checkbox"/> Right Ankle |
| <input type="checkbox"/> Head | <input type="checkbox"/> Eyes | <input type="checkbox"/> Ears | <input type="checkbox"/> Chest | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Buttocks |
- Other: _____

Please Describe the Pain and Place an "X" on the Picture:

Severity:

- Mild Mild-to-Mod Moderate Mod-to-Severe Severe

Frequency:

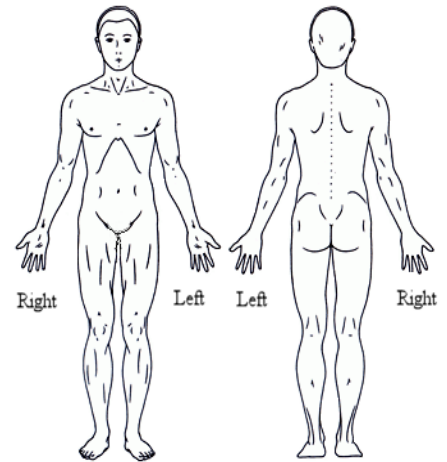
- Once Intermittent Occasional Frequent Constant

Quality:

- Dull Medium Sharp Stabbing Burning

The Pain is worse: (Check all that apply)

- Morning Midday After Work Evening Nighttime



Describe on a Scale of 1 (mild) to 10 (severe) How You Feel:

Circle One: 1 2 3 4 5 6 7 8 9 10

Have you Been Treated for this Current Condition in the Past?

Yes No When? _____ By Whom? _____

What Activities of Daily Living are you unable to perform due to your pain?

- | | | | | | |
|------------------------------------|--------------------------------------|-------------------------------------|------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting | <input type="checkbox"/> Running | <input type="checkbox"/> Climbing |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Showering | <input type="checkbox"/> Dressing | <input type="checkbox"/> Shoes | <input type="checkbox"/> Toileting | <input type="checkbox"/> Cleaning |
| <input type="checkbox"/> Self Care | <input type="checkbox"/> Family Care | <input type="checkbox"/> Child Care | <input type="checkbox"/> Home Care | <input type="checkbox"/> Driving | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Working | <input type="checkbox"/> Lifting | <input type="checkbox"/> Desk Work | <input type="checkbox"/> Traveling | <input type="checkbox"/> School | <input type="checkbox"/> Concentrate |

Describe how the pain affects these Activities of Daily Living:

Check the box that describes the pain and Activities of Daily Living (ADL):

<p>1 – No Pain</p>	<p>2 – Slight Discomfort</p>	<p>3 – Pain with No Effect on ADL's</p>	<p>4 – Pain with a Little Effect on ADL's</p>	<p>5 – Pain Prevents Any ADL's</p>	<p>6 – Pain Limits Work and Prevents Any ADL's</p>	<p>7 – Pain Prevents Both Work and ADL's</p>	<p>8 – Pain Prevents Working, ADL's and Activity</p>	<p>9 – Pain Keeps Me in Bed or Sitting at All Times</p>	<p>10 – Pain is Horrible, Cannot Tolerate Movement</p>
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ADDITIONAL COMPLAINTS: _____

PAST HISTORY:

What other conditions have you been treated for? (Explain in detail)

What Surgeries or Procedures have you had? (Explain in detail)

Medical History – (Check all that apply)

You:

- | | | | | | |
|---------------------------------------|---------------------------------------|------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alzheimer | <input type="checkbox"/> Kidney Dis. | <input type="checkbox"/> Gout | <input type="checkbox"/> Amputation | <input type="checkbox"/> Ulcers | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> COPD | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Deafness | <input type="checkbox"/> Blindness | <input type="checkbox"/> Migraines | <input type="checkbox"/> Disc Disorder | <input type="checkbox"/> Neuralgia |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Varicose Vein | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sweats | <input type="checkbox"/> Chills | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Eczema | <input type="checkbox"/> Prostrate Trouble |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Earache | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Neuro-Muscular Disease |

Other: (Be specific) _____

Your Family:

List any Current Allergies: (Be specific)

Current Medications You are Taking: (Be specific)

Social Activities:

- Smoke Cigarettes ____ # packs per day Smoke Cigars I don't smoke
 Drink Alcohol Beverages ____ # per day, or ____ # per week I don't drink alcohol.
 Beer Wine Mixed Drinks
 I admit to history of Recreational Drug Use. I deny history of Recreational Drug Use.
 I am currently Pregnant. Due Date: _____

Comments: _____

Please sign this form and thank you for visiting our office!

(Your Signature)

(Date)

Ellis H. Schauder, D.C.

(Date)