Suwanee Family Chiropractic

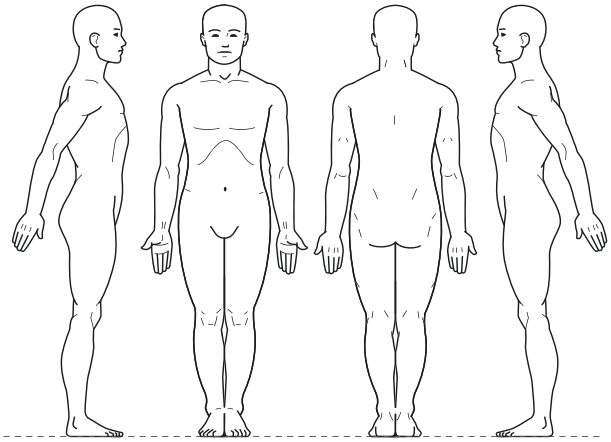
Dr. Laura Russo, DC.
525 Peachtree Industrial Blvd. Suite D
Suwanee, Georgia 30024
770.831.7556
suwaneechiro.com

Patient Intake Form

Print Patient Name _____ **Today's Date** (xx/xx/xxxx) _____

1. **Is today's problem caused by:** ☐ Auto Accident ☐ Worker's Comp ☐ Other _____

2. **Indicate on the drawings below where you have pains / symptoms:**



3. **How often do you experience your symptoms?**
   ☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (1-25%)

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 with motion

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?** *(circle one)*
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 10

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 ☐ ER Physician ☐ Massage Therapist ☐ Neurologist ☐ Orthopedist ☐ Physical Therapist
   ☐ Primary Care Doctor ☐ Other _____ ☐ No one

10. **How long have you had this problem?** _____

(Continue on the back)

11. How do you think your problem began? _____

12. Do you consider your problem 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?** _____ **age?** _____

16. How would you rate your overall health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Do you have immediate family members with any of the following?

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ 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 have a condition listed below presently, check the present column

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

Females Only

☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy

20. List all prescription medication you are currently taking: _____

_____

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

_____

22. List all surgical procedures you have had: _____

_____

23. How often do you do the following at work?

Sit:	☐ Most of the Day	☐ Half of the Day	☐ A Little of the Day
Stand:	☐ Most of the Day	☐ Half of the Day	☐ A Little of the Day
Computer Work:	☐ Most of the Day	☐ Half of 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 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 **Today's Date** (xx/xx/xxxx)