

PATIENT INTAKE PROFILE

Date _____ Name _____ Age _____ Sex _____

Next Physician Visit _____

How did you find T.Herrlinger & Assoc.?
(Please check ***ALL*** that apply)

- Your Doctor referred you to us.
- Your Case Manager referred you to us. NAME: _____
- Friend or Relative referred you to us. NAME: _____
- You were a previous patient here.
- Location/Saw our sign from the road.
- Advertising Yellow pages.com Phone Book Website
- We accept your insurance
- Other: _____

History

What is your chief complaint? _____

How did this begin? _____

What symptoms are you having?(check all that apply)

- | | | |
|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Grating | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Popping | <input type="checkbox"/> Cramps | <input type="checkbox"/> Giving Out |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Catching | <input type="checkbox"/> Locking |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Burning | <input type="checkbox"/> Other _____ |

Is your pain getting (check one) Better Worse No Change

Previous Treatment

What tests have you done for this condition? (check all that apply) :

- X-Rays EMG MRI CT Scan Myelogram Lab Tests

Please list any hobbies and/or interests _____

Patient Signature

Therapist Signature

BRIEF MEDICAL HISTORY

In an effort to better serve you, we request that you provide us with a medical history. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written signature.

LAST NAME	FIRST NAME	AGE	SEX	HEIGHT	WEIGHT
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What is your current pain level?

Pain Level At Rest 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 None Worst	Pain Level With Exertion 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 None Worst
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Are you under chiropractic care? **Yes No**

Are you pregnant? **Yes No**

ILLNESS/INJURY: Please check if you have ever had:

		HEART DISEASE			GENERAL MEDICAL CONDITIONS
Yes	No		Yes	No	
		Congestive Heart Failure (CHF)			Arthritis (rheumatoid/osteoarthritis)
		High Blood Pressure			Allergies
		Heart Attack (Myocardial Infarction)			Neurological Disease (such as MS/Parkinsons)
		Atherosclerotic Disease (CAD)			Headaches
		Angioplasty			Gastrointestinal Disease (ulcer, hernia, reflux)
		Stents			Visual Impairment (cataracts, glaucoma or macular degeneration)
		Arrhythmia			Back Pain (neck, low back, degenerative disc disease, spinal stenosis)
		Coronary Artery Bypass Graft (CABG)			Hepatitis/AIDS
		Angina			Osteoporosis
		Pacemaker/Defibrillator			Anxiety or Panic Disorders
Yes	No	VASCULAR DISEASE			Depression
		Peripheral Arterial Disease			Cancer
		Acquired Respiratory Distress Syndrome			Kidney, Bladder, Prostate or Urination problems
		Diabetes			Incontinence
		Stroke/TIA			Hearing Impairment
Yes	No	LUNG DISEASE			Sleep Dysfunction
		Chronic Obstructive Pulmonary Disease (COPD)			Prosthesis/Implants
		Emphysema			
		Asthma			
		Recent Pneumonia			
		Chronic Bronchitis			
		SURGERIES (Please list with dates)	???HOW DID YOU FIND T. HERRLINGER???		
DATE			Please check all that apply		
			1. Your Doctor referred you to us		
			2. Your Case Manager referred you to us		
			NAME: _____		
			3. A Friend or Relative referred you to us		
			NAME: _____		
			4. You were a previous patient here		
			5. Location / saw our sign from the road		
			6. Advertising <input type="checkbox"/> 7. Yellow Pages.com		
			8. Advertising - Phone Book		
			9. Advertising - Our Website		
			10. We accept your insurance		
			11. Other		

MEDICATIONS: Please list your current medications and their dosages:

ALLERGIES (food, medication, other)

Patient Signature (parent if patient is a minor)

Date: