The Back & Neck Pain Center of Monterey

1299 Pacific Street * Monterey, CA * 93940
831-657-0191

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Name (First, MI, Last): _____Today's date: _____

Address: _____City:_____ State:_____ Zip: _____

Phone (Cell):_____Email Address:_____

Date of birth:____/____/____ Age:_____ ▢ Male ▢ Female

Status: ▢ Single ▢ Married ▢ Divorced ▢ Widowed ▢ Separated

Emergency Contact: _____ Relation: _____ Phone:_____

How did you hear about our office? ▢ Website ▢ Yelp Other:_____

Whom may we thank for referring you?_____

Do you have health insurance? ▢ Yes ▢ No Insurance company name: _____

(Have you already given the staff your insurance information if you are interested in using insurance?)

PATIENT CONDITION

Please describe reason for visit:_____

Have you ever had the condition? ▢ Y ▢ N If yes, when?_____

Nature of Injury: ▢ Auto Accident ▢ Work Injury ▢ Other ▢ N/A

Have you made a report if any auto or work accident? ▢ Y ▢ N

Date of Accident:_____ Date symptoms appeared: _____

What treatment have you already received for your condition?

▢ Chiropractic ▢ Physical Therapy ▢ Surgery ▢ Medication ▢ None ▢ other_____

Name of other Dr.'s that have treated you for your condition_____

Have you ever had spinal surgery? ▢ Yes ▢ No If yes, please describe below and give approximate date:

_____

Have you had any joint replacements? ▢ Y ▢ N Hip ▢ R ▢ L Knee ▢ R ▢ L Shoulder ▢ R ▢ L

Please list any major auto accidents or slips/falls in your history with approximate dates _____

_____

If yes, please describe below and give approximate date:_____

_____

Are you currently taking any medication? ▢ Yes ▢ No If yes, please list below: _____

_____

_____

HEALTH HISTORY

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE ANY MEDICAL HEALTH PROBLEMS?

☐ Arthritis	☐ High Blood Pressure	☐ Stroke	☐ Epilepsy/Seizure
☐ Heart Attack	☐ Kidney Disorder	☐ Hernia	☐ Thyroid Condition
☐ Digestive Disorders	☐ Sinus Condition	☐ Glaucoma	☐ Fibromyalgia
☐ Asthma	☐ Cancer	☐ Hypoglycemia	☐ HIV/Aids
☐ Polio	☐ Circulation Problems	☐ Emphysema	☐ Lyme Disease
☐ Heart Condition	☐ Prostate Problem	☐ Female Disorder	☐ Carpal Tunnel
☐ Bowel Disorder	☐ Ear Condition	☐ TMJ Problem	☐ Chronic Fatigue
☐ Foot Problems	☐ Diabetes	☐ Anemia	☐ No Health Problems

Allergies_____

Other _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING DISEASES?

☐ **Cancer**	▢ Grandparents	▢ Father	▢ Mother	▢ Siblings	▢ Children
☐ **Diabetes**	▢ Grandparents	▢ Father	▢ Mother	▢Siblings	▢Children
☐ **Heart Disease**	▢ Grandparents	▢ Father	▢ Mother	▢ Siblings	▢ Children
☐ **High Blood Pressure**	▢ Grandparents	▢ Father	▢ Mother	▢ Siblings	▢ Children
☐ **Stroke**	▢ Grandparents	▢ Father	▢ Mother	▢ Siblings	▢ Children
☐ **Arthritis**	▢ Grandparents	▢ Father	▢ Mother	▢Siblings	▢ Children
☐ **Back/Neck Problems**	▢ Grandparents	▢ Father	▢ Mother	▢Siblings	▢ Children

SOCIAL HISTORY

1. Do you eat what you think is a well balanced diet? ▢ Yes ▢ No
2. Do you exercise regularly? ▢ Yes ▢ No
3. Do you sleep 6-8 hours per night? ▢ Yes ▢ No
4. Do you take daily vitamins? ▢ Yes ▢ No
5. Do you drink 6-8 glasses of water per day? ▢ Yes ▢ No
6. Do you drink more than a couple cups of coffee each day? ▢ Yes ▢ No
7. Do you drink more than a couple glasses of soda each day? ▢ Yes ▢ No
8. Do you drink alcoholic beverages? ▢ Yes ▢ No
9. Do you smoke or use tobacco products? ▢ Yes ▢ No
10. Do you have a stressful home or work environment? ▢ Yes ▢ No

SUBJECTIVE COMPLAINT FORM

1. **Name:** _____ **Date:** _____ **Staff Use: ID#**_____

2. **Main complaint:**_____

3. **Type of Problem:** ▢ New Problem ▢ Return of the Same Problem ▢ Always Same Problem, Worse Now

4. **Caused by:** ▢ lifting ▢ bending ▢ reaching ▢ over exertion ▢ repetitive motion
   (choose one) ▢slip/fall ▢ slept wrong ▢ unknown ▢ gradual worsening ▢ no injury
   Describe the onset/injury:_____

5. **Quality of Pain:** ▢ sore ▢ stiff ▢ ache ▢ tight ▢ sharp ▢ stab ▢ shoot ▢ catch
   (check all that apply) ▢ burn ▢ throb ▢ numb ▢ tingle ▢ asleep ▢ other:_____

   Severity: With Activity **0** no pain **1** **2** mild pain **3** **4** moderate pain **5** **6** **7** severe pain **8** **9** extreme pain **10**

   At Rest **0** no pain **1** **2** mild pain **3** **4** moderate pain **5** **6** **7** severe pain **8** **9** extreme pain **10**

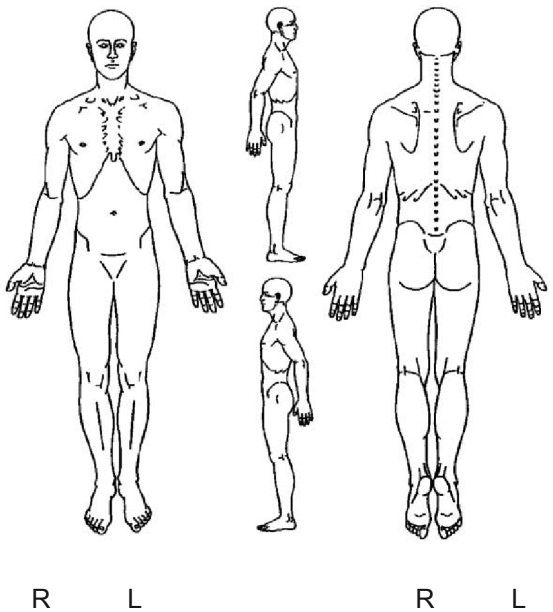
7. **When did this start?** Started or worsened:(approximately)_____

8. **Have you had similar problems?** Last episode/Last occurred:_____ ▢ No similar problem in past

9. **Timing:** *(check all that apply to you)*

   Worse: ▢ morning ▢ daytime ▢ night time ▢ with activity ▢ with inactivity ▢ same all day
   Better: ▢ nothing helps ▢ moving ▢ stretching ▢ applying heat ▢applying cold ▢ resting
   ▢ OTC meds ▢ Rx meds ▢ lying down ▢ sitting ▢standing ▢ walking

10. **Other Symptoms:**
    ▢ headaches ▢ tingling/numb ▢ joint stiffness ▢ muscles spasms ▢ muscle knots ▢ chronic fatigue
    ▢ sleep problems ▢ hard to walk ▢ hard to breathe ▢ cold hands/feet ▢ dizziness ▢ swelling
    ▢ nausea/vomiting ▢ heartburn ▢ blurred vision ▢ depression ▢ anxiety/panic ▢ mood swings

11. Difficulty with ADL's (Activities of daily living)	**Mild Pain** But can do	**Moderate Pain** Limits ability	**Severe Pain** Unable to do	**Shade the Areas of Symptoms**
Sleeping	▢	▢	▢	
Bending Over	▢	▢	▢	
Prolonged Sitting	▢	▢	▢	
Prolonged Standing	▢	▢	▢	
Prolonged Walking	▢	▢	▢	
Getting Up From Sitting	▢	▢	▢	
Climbing Stairs	▢	▢	▢	
Driving	▢	▢	▢	
Extended Computer Use	▢	▢	▢	
Household Chores	▢	▢	▢	
Yard Work	▢	▢	▢	
Getting Dressed	▢	▢	▢	
Lifting/Straining	▢	▢	▢	
Turning/Moving Head	▢	▢	▢	
Rolling Over/Twisting	▢	▢	▢	
Reaching Up/Out	▢	▢	▢	
Using Arms	▢	▢	▢	
Exercise	▢	▢	▢	
Job, Occupational Work	▢	▢	▢	

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